PATIENT INFORMATION

PLEASE PRINT

FULL NAME:_____ DOB:_____ GENDER: MALE/FEMALE

HOME ADDRESS:_____ CITY:_____ZIP:_____

PREFERRED NUMBER:_____DAYTIME:_____CELL:_____

SOCIAL SECURITY:_____ MARITAL STATUS: NOT MARRIED/ MARRIED/ DIVORCED/ WIDOWED

EMAILADDRESS:_____PCP:_____

EMERGENGYCONTACT:_____RELATIONSHIP:_____PHONE:_____

REFERRING PHYSICIAN/HOW DID YOU HEAR ABOUT US?_____

PHARMACY(LOCATION/PHONENUMBER):_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE: _____ PHONE:_____

POLICYHOLDER:_____DOB:_____SS#_____GENDER:MALE/MALE

POLICY #:_____ GROUP#:_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE: _____ PHONE: _____

POLICY HOLDER:_____ DOB: _____ SS# _____ GENDER: MALE/FEMALE

POLICY #:_____ GROUP#_____

*******PLEASE BE READY TO PROVIDE PROOF OF INSURANCE AND ID TO RECEPTIONIST*******

MINOR INFORMATION IF PATIENT IS A MINOR (18 YEARS OR YOUNGER) PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME:_____ PHONE#_____

FATHER'S NAME: _____PHONE#_____

A PARENT OR LEGAL GUARDIAN MUST BE PRESENT FOR ANY TREATMENT OF MINORS

WHAT IS YOUR ETHNICITY: ___HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ____**DECLINE**

WHAT IS YOUR RACE: (CHOOSE ONE OR ALL CATEGORIES THAT BEST DESCRIBES YOUR RACE)

____WHITE ____ AMERICAN INDIAN/ALASKA NATIVE ____ BLACK OR AFRICAN AMERICAN ____INDIAN _____ ASIAN

____ NATIVE HAWAIIN OR PACIFIC ISLANDER _____ HISPANIC _____OTHER _____**DECLINE**

PRIMARY LANGUAGE SPOKEN: _____

PLEASE READ AND SIGN BELOW:

I/We, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. I hereby authorize Perri Dermatology to furnish information to insurance carriers concerning my illness and treatments. It is customary that payment be made when the service is rendered. I authorize benefits payable to the above practice. I understand I am responsible for any amount not covered by insurance.

_____

DATE **PATIENT/RESPONSIBLE PARTY SIGNATURE**

Perri Dermatology, PLLC
Anthony J. Perri, M.D.
BOARD CERTIFIED DERMATOLOGIST

Pathology Billing Information

There are two components to your Pathology billing – the technical (or processing) component and the professional (or reporting) component. Our office will make a reasonable attempt to inform patients of their insurance carrier's preferred laboratories, however, it is a patient's responsibility to know their benefits and inform us of the correct laboratory if a patient believes information provided to him/her is incorrect. Quest, LabCorp or your laboratory of choice will bill your insurance company for the processing and interpretation of the specimen(s) submitted. Quest and LabCorp Laboratories are the two most commonly listed as "Preferred" with most insurance carriers.

Depending on your specific insurance carrier, you may have a patient balance after the insurance pays your claim. If there is a patient balance owed you will receive a bill from the laboratory.

If you have questions regarding your bill for pathology services, please contact the laboratory's billing department.

As a patient, you may request for your specimen to be sent to a laboratory other than the one listed by your carrier as being "Preferred" or "In-network". Patient may elect a non-preferred laboratory if desired, keeping in mind that this may incur out-of-network rates and assuming all responsibility for this decision. Please inform your medical assistant of your laboratory of choice if different than your insurance carrier's "Preferred" Laboratories at the time of specimen collection.

_____

Patient Signature Date

Perri Dermatology, PLLC
Anthony J. Perri, M.D.
BOARD CERTIFIED DERMATOLOGIST

PATIENT LABEL

CONSENT TO TREATMENT IN DERMATOLOGY

I voluntarily give my consent for treatment and also my consent to any procedures that D. Perri performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injection of skin lesions, cauterization of skin lesions. Dr. Perri will discuss in detail any procedure he plans to perform, answer all questions relating to the procedure and obtain oral informed consent in the exam room.

Signature of Patient or Legal Guardian Date

Printed Name of Patient or Legal Guardian Relationship to Patient

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Signature of Witness Date

Perri Dermatology, PLLC
Anthony J. Perri, M.D.
BOARD CERTIFIED DERMATOLOGIST

PATIENT LABEL

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I (patient's name), _____, give my authorization to release my Protected Health Information including results of my laboratory test, x-ray and/or other test results to the following designated representative(s):

Initials (Patient or Legal Guardian)

_____ My spouse (Name)_____

_____ My child (Name)_____

_____ Other (Name)_____

_____ Personal Representative_____

_____ May be left on my home answering machine. _____

_____ May be left on my work answering machine._____

_____ May be left on my cell phone._____

_____ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.**

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Witness Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, **Perri Dermatology, PLLC** must receive the revocation in writing. The revocation must include, 1,) Patient's Name, address, and DOB, 2.) The patient's desire to revoke the authorization, 3.) Effective date of revocation and the patient's signature. **All revocations must be sent in writing to Perri Dermatology, PLLC 4015 IH-45 North, Conroe, Texas 77304.**

Patient Consent for Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain Patient Rights regarding my protected health information.

I understand that **Perri Dermatology, PLLC** may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payments; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Perri Dermatology, PLLC has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, **Perri Dermatology, PLLC** will provide me with the most current Notice of Privacy Practices. **Perri Dermatology, PLLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to**: Alba Galvez, 4015 I 45N, Conroe, Texas 77304.**

With this consent**, Perri Dermatology, PLLC** may call my home or other alternative location and leave a message on voice mail or in person, may e-mail, or mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, letters, emails, texts, and patient statements. I have the right to request that **Perri Dermatology, PLLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow **Perri Dermatology, PLLC** to use and disclose my protected health information to carry out treatment, payment, and health care operations. With this consent **Perri Dermatology, PLLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

_____ _____

Patient's Signature or Legal Guardian Date

_____ _____

Print Patient's Name Legal Guardian's Name, if applicable (Print)

Perri Dermatology, PLLC's Financial Policy

Thank you for choosing us for your dermatology needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full is required at each visit. We must verify coverage and benefits with insurance carriers. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a breach of contract. Please help us maintain our contract by paying your co-payment/deductible at each visit.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full.

Proof of insurance. All patients must complete our patient information form at check-in time. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Non-payment. If your account is over 180 days past due, you will be notified on your statement. Partial payments will not be accepted unless payment arrangements have been made. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time availability to another patient. We reserve the right to charge $25 for appointments that are not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments. If you miss a surgery appointment your account may be charge $75. Surgery appointments require a minimum 48 hours cancellation notice. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party/ Date