

Phone  
(816) 942-1150

**Patient Information Sheet**  
Dermatology Specialists of Kansas City, P.C.

Fax  
(816) 942-0322

Patient Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F

Marital Status: S M W D Spouse/Partner Name \_\_\_\_\_ Spouse/Partner work or cell # \_\_\_\_\_

Employer (company name if self employed) \_\_\_\_\_ Occupation: \_\_\_\_\_

Doctor that referred you to our office \_\_\_\_\_ Dr. Phone # \_\_\_\_\_

Emergency Contact (not living with you) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE INFORMATION – In order to bill your insurance company, this section must be completed in full.**

\*\***PRIMARY** Insurance Policy \_\_\_\_\_ Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Customer Service Phone # \_\_\_\_\_ Co-pay \_\_\_\_\_

**Policy Holder's Information (If different than patient)**

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ S.S. # \_\_\_\_\_ Sex: "M" F  
(Last) (First) (M.I.)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: Spouse Parent

Employer: \_\_\_\_\_ Work # \_\_\_\_\_

\*\***SECONDARY** Insurance Policy \_\_\_\_\_ Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Customer Service Phone # \_\_\_\_\_ Co-pay \_\_\_\_\_

**Policy Holder's Information (If different than patient)**

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ S.S. # \_\_\_\_\_ Sex: "M" F  
(Last) (First) (M.I.)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: Spouse Parent

Employer: \_\_\_\_\_ Work # \_\_\_\_\_

**\*\* THIS PERSON MUST BE PRESENT TO SIGN OUR FINANCIAL POLICY ON PAGE 2 \*\***

**PERSON RESPONSIBLE FOR PAYMENT**

Relationship: Self Mother Father Step Parent Legal Guardian Other \_\_\_\_\_

**\*\*IF OTHER THAN PATIENT, PLEASE FILL OUT INFORMATION BELOW\*\***

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone #: \_\_\_\_\_ "Work #: \_\_\_\_\_ "Cell # \_\_\_\_\_

## Dermatology Specialists of Kansas City, P.C.

**HOW DID YOU HEAR ABOUT US?** (Please Circle One)

Advertisement      My Doctor      A Family Member      A Friend      Phone Directory      Insurance Directory      Internet

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**I AM INTERESTED IN ADDITIONAL INFORMATION ON ...**

- A Skin Care Plan       Skin Rejuvenation       Botox       Chemical Peels  
 Treatments of Leg or Facial Veins       Treatment of Wrinkles/Sun Damage       Hair Removal
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### **RECORD RELEASE AND ASSIGNMENT OF BENEFITS**

I hereby authorize Dermatology Specialists of Kansas City to release pertinent information regarding my care to other physicians involved in my case and/or insurance companies holding policies on me. I authorize my insurance company to directly remit payment to Dermatology Specialists of Kansas City for medical or surgical services provided and billed.

Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

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### **FINANCIAL POLICY**

Since your insurance policy is a contract between you and your insurance company, you are responsible for the cost of services you receive from Dermatology Specialists of Kansas City. Co-payments and deductibles are payable at the time of service. If your insurance policy requires a referral, we must have it at the time of your visit or you will be asked to reschedule your appointment. We will allow 45 days for your insurance company to pay your claim. After 45 days, payment is your responsibility should your insurance company pay at a future date a refund will be issued. A \$25 processing fee will be added to your account if it is submitted to our collection agency for non-payment or if your check is returned to us by your bank. If you must cancel your appointment, please call the office at least 24 hours in advance and our receptionists will be happy to assist you. Patients who repeatedly miss appointments or cancel with less than 24 hours notice may be discharged from care or asked to pre pay for their appointment at the time of booking. If you are more than 15 minutes late, we will do our best to accommodate you, but your visit time may be delayed.

I have read and fully understand Dermatology Specialists of Kansas City's financial policy

**\*\*\*\*THIS SHOULD BE SIGNED BY THE PERSON RESPONSIBLE FOR PAYMENT. \*\*\*\***

Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

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### **HIPAA PATIENT CONSENT**

A copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information, is available to you at the front desk. Please sign below to acknowledge receipt of the Notice.

Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

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### **AUTHORIZATION TO DISCUSS MEDICAL INFORMATION (OPTIONAL)**

I authorize \_\_\_\_\_, who is my \_\_\_\_\_ to have access to/discuss my medical records.  
(Relationship)

Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

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**\*\*A PARENT OR GUARDIAN MUST ACCOMPANY A MINOR TO THE INITIAL VISIT. \*\***

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### **MINOR CONSENT (THIS SHOULD BE SIGNED IF THE MINOR WILL NOT BE WITH A PARENT, EXCEPT FOR THE INITIAL VISIT)**

I give the doctors and staff at Dermatology Specialists of Kansas City permission to treat \_\_\_\_\_ in my absence.

Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_