Phone **(816)942-1150**

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

Fax **(816)942-0322**

Patient Name: _____ Today's Date: _____
LAST FIRST MIDDLE

Social Sec #: _____ Date of Birth: _____

Patient Age: _____ Sex : ☐Male ☐Female Marital Status: ☐S ☐M ☐D ☐W

Home address: Street: _____ Apt #_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

EMAIL ADDRESS: _____

Spouse/Partner Name: _____ Phone _____

Referring Physician: _____ Phone _____

Employer: _____ Occupation:_____

Employer Address: _____ Employer Phone: _____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: _____ Alternative Phone: _____

FOR YOUR PRIVACY PLEASE NOTE THAT WE MAY CONTACT THIS PERSON IF WE CAN NOT CONTACT YOU

Primary Insurance Name: _____

Policy/ID #: _____ Group #: _____

Subscriber name: _____DOB: _____SS#: _____

Secondary Insurance Name: _____

Policy/ID #: _____ Group #: _____

Subscriber name: _____DOB: _____SS#: _____

It is important that we identify your health coverage. Some patients are covered by more than one health insurance policy. Most health insurance carriers coordinate benefits. This means both companies share the responsibility of covering the patient's medical expenses paying no more than 100% of the billed charges. This avoids duplication of payments, which would result in higher premium rates.

DO YOU HAVE HEALTH INSURANCE COVERAGE THAT YOU HAVE NOT REPORTED TODAY?
[ ] YES [ ] NO

Signature:_____ **Date:** _____
(Patient *or* Parent/Legal guardian)

Dermatology Specialists of Kansas City

I certify that I have insurance coverage with the company (ies) listed in the previous page of this paperwork. I assign directly to Dermatology Specialists of Kansas City, PC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions and claims. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named doctors may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. To insure the continuity of care, I also authorize Dermatology Specialists of Kansas City, PC to provide the information regarding my treatment and any medication I received at this office to my **primary care physician**.

☐ *****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: ____ Date: ________________________________

(Patient *or* Parent/Legal guardian)

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☐ **Medicare Patients Please Sign** I request that payment of authorized Medicare benefits be made on my behalf to Dermatology Specialists of Kansas City, PC for any services furnished to me by their physicians or nurse practitioner. I authorize any holder of medical information about me to release to CMS(Center of Medicare&Medicaid) and its agents any information needed to determine these benefits or the benefits payable for the related services.

Signature:____ Date: ________________________________

(Patient *or* Parent/Legal guardian)

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PATIENT PORTAL INSTRUCTIONS AND CONSENT

Access to this secure Patient Portal is an optional service, and you may suspend or terminate it at any time and for any reason. I understand that my access to this Portal will not affect the current level of care I'm already receiving from Dermatology Specialists of Kansas City. I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the patient portal and agree that I understand the risk associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Dermatology Specialists of Kansas City should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I understand that this agreement will remain in effect for 12 months. At the end of that time, I will be asked to renew my confidential email and Patient Portal Login. It is my responsibility to notify Dermatology Specialists of Kansas City if there is a change in my email account or I feel that my secure password has been breached. I agree not to hold Dermatology Specialists of Kansas City or any of its staff liable for network infractions beyond its control.

Please print all information clearly YOU MUST PROVIDE EMAIL ADDRESS TO REGISTER FOR THE PATIENT PORTAL

Patient Full Name ____ Date of Birth _______________________

Please enter confidential e-mail address if different than email listed on page 1

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Upon signing this document, your signature is your agreement to the Policy and Procedures for our Patient Portal AND indicates complete and accurate information has been provided.

☐**ACCEPT PATIENT PORTAL** ☐**DECLINE PATIENT PORTAL**

Print Name ____

Signature ____ Date _________________________________

(Patient *or* Parent/Legal guardian)

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 $35 processing fee will be added to your account if it is submitted to our collections 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: _____

Print Name : _____ Date: _____

Relationship to Patient: _____ Phone: _____

Address: _____
City State Zip

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☐ **AUTHORIZATION TO DISCUSS INFORMATION (OPTIONAL)**

I authorize _____, who is my _____ to have access to/discuss my medical records.
Relationship

Signature:_____ **Date:** _____
(Patient *or* Parent/Legal guardian)

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☐ **MINOR CONSENT **A PARENT OR GUARDIAN MUST ACCOMPANY A MINOR TO THE INITIAL VISIT****

I give the providers and staff at Dermatology Specialists of Kansas City permission to treat minor :

_____

Signature:_____ **Date:** _____
(Patient *or* Parent/Legal guardian)

*** A fee may be charged for missed appointments without 24 hour notice**