Argyll Skincare

Laura Taylor PA-C   Bob Kurts PA-C

(PLEASE PRINT)

PATIENT INFORMATION

LAST NAME________________ FIRST________________ MIDDLE__________
CELL PHONE____________ ALT/HOME PHONE____________ EMAIL________________
ADDRESS________________________ APT # ____________
CITY________________________ STATE____________
ZIP CODE ____________ EMPLOYER/SCHOOL________________
WORK PHONE____________ DATE OF BIRTH______ SEX___ MARITAL STATUS__________
SSN________________ RACE_________ ETHNICITY:____ LANGUAGE:____________
HOW WERE YOU REFERRED?____________ EMERGENCY CONTACT NAME:________________
RELATION:________________ NUMBER:________________

RESPONSIBLE PARTY INFORMATION

NAME________________________ RELATIONSHIP____________ DATE OF BIRTH____________
SSN____________ HOME PHONE____________ WORK PHONE ____________
ADDRESS____
IF MINOR: MOTHER____________ FATHER____________ LEGAL GUARDIAN____________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY________________________ Group number ____________
Policy Number____________ Subscriber____________ Subscriber DOB ____________
Relation to patient____________ Address (if diff than patient) ________________
SECONDARY INSURANCE COMPANY________________________ Group number ____________
Policy number____________ Subscriber____________ Subscriber DOB ____________
Relation to patient____________ Address (if diff than patient) ________________

RELEASE OF MEDICAL INFORMATION

I, by my signature on the back of this form, as the patient OR his/her representative, do hereby authorize **Argyll Skincare**, to release to my insurance company(s) or other appropriate agency(s) that information which is necessary to validate this claim. **Argyll Skincare**, is also hereby authorized to release to my physician(s), whether as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes. I hereby authorize **Argyll Skincare**, to release any medical information to physicians other than original referring providers, who may be involved in my or my dependent's health care treatment, when requested by these physicians/ PA's. By signing this consent, information will be given to requesting providers without further signed authorization. I hereby give permission to disclose, discuss and speak to listed individual(s) concerning my medical or financial information including, appointments, test results, prescriptions, school or work excuses, etc. (We ***must*** have each individual listed by name. This includes your spouse, children, parents, etc.)

☐ **RELEASE MY MEDICAL INFORMATION TO:**

Name________________________ Phone____________ Relationship____________
Name________________________ Phone____________ Relationship____________
Name________________________ Phone____________ Relationship ____________

☐ **RESTRICT/DO NOT RELEASE ANY INFORMATION**

May we leave personal information on your answering machine? Yes No ***Text to your cell phone?*** Yes No

Send to your email address? Yes No

☐ **I request to be web enabled thru *eClinical* for secure access to information related to my care. I will be emailed the instructions and password for web access:**

Email: ____

Do you have an *Advanced Directive (Living Will)*? Yes No **If YES, does anyone make medical decisions on your behalf?** Yes No **Medical Decision Maker Name:**________________________

Phone: ____________________

PLEASE INITIAL EACH SECTION BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE INFORMATION:

____**ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY.** I do, hereby authorize payment of my insurance benefits, including authorized Medicare benefits, basic and major medical for the services I receive, to be made directly to **Argyll Skincare.**

____**CONSENT FOR MEDICAL SERVICES.** I authorize **Argyll Skincare** to render treatment to me or my dependents for dermatological care or medical procedures as deemed medically necessary for treatment as indicated.

____**REFERRALS/AUTHORIZATIONS** I understand that if my insurance requires a referral or an authorization, I am responsible for obtaining the referral prior to my visit. If I do not have a referral or authorization at the time of my visit, I may be rescheduled or sign a waiver of financial responsibility. In such case I understand that full payment will be required at the time of service.

____**FINANCIAL RESPONSIBILITY** I understand that although **Argyll Skincare** will file a claim to my insurance plan(s), I am expected to pay my copayment, coinsurance, deductible and non-covered services amounts at the time services are rendered. I acknowledge that **Argyll Skincare** does not guarantee payment of my claim by my insurance plan and that it is my responsibility to know the provisions of my insurance. Not all procedures are deemed "Medical Necessity" by insurance carriers and can be considered cosmetic. For example-Skin tag removal, correction of dark spots, yearly skin cancer screenings <u>without</u> specific areas of concern, would not be a covered service. I understand that I would be responsible for payment of such services. I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

I also understand that any prior unpaid balances on my account must be paid in full before being seen by a provider. If my prior balance cannot be paid in full, I will speak with a financial counselor at **Argyll Skincare** to make a payment arrangement before services can be rendered.

I also understand that if **Argyll Skincare** does not participate with my insurance plan that I will be expected to pay in full for my services. And it is my responsibility to know if **Argyll Skincare** is in network with my insurance plan.I understand that payments to **Argyll Skincare** can be made by cash, checks and all major credit cards. I also acknowledge that returned checks will be subject to a non-sufficient fund fee of $25.00.

____**COSMETIC SERVICES.** Cosmetic services are not a covered benefit under insurance plans. I understand that to make an appointment for cosmetic services, I will need to schedule a consult with the provider. At that appointment, a plan for cosmetic services will be established.

____**PATIENT RESPONSIBILITY.** I understand that due to Federal (red flag) rules that **Argyll Skincare** is prevented from filing to my insurance without proof of identification. I will be expected to present a photo ID and insurance card(s) at every office visit. I will also update any changes to my addresses, telephone numbers and insurance if they have changed since my last visit and I understand that I will be asked to update my demographics and signatures annually.

____**MISSED APPOINTMENTS** It is my responsibility to notify Argyll Skincare at least *24 hours* prior to my appointment if I am unable to keep the appointment. I acknowledge that if I miss two appointments without sufficient notification that I will be charged a $35 fee. If I miss three appointments without sufficient notification, I will be dismissed from the practice for non-compliance.

____**PRIVACY POLICY NOTICES**. I have been offered a copy of Argyll Skincare's *Notice of Privacy Policies* that details how my personal health information may be used, disclosed and my rights as permitted by federal law. As well I understand that this notice is posted for my benefit in the reception areas and on the website of Argyll Skincare.

____**ePRESCRIBING CONSENT**. I acknowledge that Argyll Skincare utilizes electronic health records and will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my pharmacy provider. To enable electronic prescriptions to my pharmacy, I grant Argyll Skincare my permission to access my medication history to view current and past prescription information.

____**MEDICATION REFILLS**. For fastest results, please call your pharmacy and ask them to fax a refill request to our office. Our fax number is (530) 809-2639, If your prescription is older than 6 months you may be required to see a provider. Many medications require prior authorization and our office will contact your insurance company to receive approval for the medication you desire. Please allow 72 hours for a normal prescription refill. Do not wait until you are out of medication.

Please designate the pharmacy you will use for medications:

Pharmacy____Phone___________________________

Address ____

____**LAB SERVICES** I am aware that my laboratory/pathology services may not be billed from **Argyll Skincare**. I will receive a separate statement from the lab or pathologist. In addition, it is my responsibility to contact my insurance plan to determine what laboratory is in network for my plan.

PATIENT/GUARDIAN SIGNATURE: ____ **DATE:** ________________

WITNESS: ______________________________________