North County Dermatology Clinic, P.A.

Timothy E. Knight, M.D.

PATIENT INFORMATION *(please print)*

Name _____ _____ _____
First *M.I.* *Last*

Street _____ Apt / Lot# _____

City _____ State _____ Zip _____

SS# _____ Date of Birth _____ Gender: M _____ F_____

Email Address _____

Marital Status: Single _____ Married _____ Widowed _____

Preferred Language: English _____ Spanish _____ Other _____

Ethnicity: Caucasian _____ Hispanic _____ Other _____

Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( ) _____

If Patient is a minor, name of legal guardian: _____

Relationship to patient: _____

Name of person with financial responsibility, if different from above: _____

Alternate Address:

Street _____ Apt / Lot # _____

City _____ State _____ Zip _____

What month are you usually at this address? _____

Please present all insurance cards and a photo ID at time of check in:

Are you the primary insured? _____ If not, and you are covered under someone else's policy, please complete the following:

Insured's Name _____ Birthdate _____ Relationship _____

Address (if different) _____ Phone: ( ) _____

Pharmacy: _____ Specific Location: _____

Primary Care Physician: _____

OVER ⇨

North County Dermatology, P.A.

Please read and sign below:

AUTHORIZATION FOR EXAMINATION AND TREATMENT: I hereby authorize examination and treatment, including any biopsy(ies) or procedures. I understant that any procedure involves risks including, but not limited to, bleeding, infection, and scarring. I am aware that a scar can result from any procedure and the severity of such scarring can not always be predicted before the procedure.

I am also aware that all specimens will be sent to a laboratory for interpretation (pathology) and this will incur an additional fee. If I do NOT want my specimen sent, a waiver must be signed before procedure is performed and the doctor or physician assistant must be notified prior to performance of the procedure.

FINANCIAL RESPONSIBILITY: I understand that it is my responsibility to know my insurance benefits. My participating insurance company will be billed for covered services according to the contract with them. I understand that I am responsible for any charges not paid in full by my insurance company. I also understand that I will be responsible for legal fees, collection fees and costs incurred to collect the balance. I acknowledge that there will be 29% added to my balance if my account is sent to the collection agency and will also be my responsibility. *I may receive separate billing from an outside laboratory for any charges resulting from tissue examination.*

I am prepared today to pay all applicable co-payments, coinsurance, deductibles, and non-covered services. We accept cash, personal check (via Telecheck), Visa, MC, Discover, and CareCredit.

My signature below signifies my understanding and acceptance of these policies and assignment of benefits from my insurance to North County Dermatology Clinic. Guardian signature accepts of personal financial responsibility for patient's charges.

Signature of patient or guardian _____ Date _____

Print Name _____ Relationship to Patient of Guardian _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Your privacy is our priority. We will not discuss your health information unless authorized by you. I have had the opportunity to read the full HIPAA Policy available at the front desk. I hereby authorize North County Dermatology Clinic, P.A., Dr. Knight and / or his staff, to disclose any or all of my health information to the following person(s) as indicated below:

Name	Relationship	Diagnosis	Treatment	Billing	Appointments

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to North County Dermatology. Unless otherwise stated, this authorization is valid for 365 days from the date of signature.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Signature of Witness (staff): _____ **Date:** _____