BEAIRD dermatology

Patient Information

Patients First and Last Name:	Prefix:	Nickname:	Date of Birth: (mm/dd/yyyy)
Status (please circle one) Single Married Divorced Widowed Partner	Sex:	Occupation:	Student (circle): Yes No

Home Phone:	Cell Phone:	Work Phone:	Preferred Phone: (circle) Home Work Cell	May we leave a message (circle): Yes No

Street Address:	City/State:	Zip Code:
Email Address:	Patient Employer:	

Do you give our office permission to discuss your medical information with Emergency Contact? YES NO

Emergency Contact Name:	Relationship:	Phone Number:
Primary Care Physician:	Referral Source:	Referring Physician:

Parent, Spouse, or Legal Guardian (if different from patient)

First Name:	Last Name:	Phone Number:
Street Address:	City/State:	Zip Code:

Insurance Information (if not present at visit)

Insurance:	Member ID Number:	Group Number:
Policy Holder's Name:	Relationship:	Date of Birth (mm/dd/yyyy)

Cancellation and No-Show Policy: If you are unable to keep an appointment for any reason, we ask that you kindly provide us with a minimum of 24-hour notice. If you are unable to give notice, you will incur a no-show or last-minute cancellation fee of $50 for general dermatology appointments, $75 for any cosmetic or aesthetic appointments, or $100 for injectable appointments.

Late Arrival: We understand that delays can happen, however, we must try to keep the other patients and our providers on time. *If you do not contact us advising us that you are delayed or have received a verbal "okay" and are 10 minutes past your scheduled appointment time, we may have to reschedule your appointment.

Insurance Authorization and Assignment I hereby authorize Beaird Dermatology, S.C. to furnish information to my insurance carriers concerning my diagnosis and treatments, and I assign to Beaird Dermatology, S.C. all payments due for services rendered to myself or my dependents if I do not make payments in full for such services. In addition, I agree to pay all applicable copayments and deductibles at the time of service.

Financial Policy: Beaird Dermatology has contracts with many insurance plans. Due to the numerous healthcare plans available, it is the patient's responsibility to verify that we are in network with your specific insurance plan. You will be responsible for any co-pays, deductibles, purchased products, and/or non-covered services. If you do not have one of the plans with which we are contracted, the total cost of your visit is required at the time of service. ***Payment Methods*:** We accept cash, personal checks, Visa, MasterCard, Discover and CareCredit.

Acknowledgement of Review and/or request of HIPAA Policies

Under the Federal HIPAA laws, we are mandated to provide our patients with a copy of our Patient Privacy Policies. The notice provides detailed information about how Beaird Dermatology, S.C. may use and disclose my confidential information. I understand that Beaird Dermatology, S.C. has the right to change his or her privacy practices that are described in the notice and a revised notice will be provided to me upon request. Your signature is your acknowledgement that you have either received or were offered a copy today and that you have reviewed this form and our policies.

Signature of Patient or Guardian Print Name Date