SOLANO DERMATOLOGY ASSOCIATES

A Medical Corporation Established 1949

Account#: Today's Date: / /

1. Patient Information (Required)

Patient Name_____

SSN _____- _____ - _____Date of Birth_____/_____/_____ Sex ❑ M ❑ F Marital Status ❑ S ❑ M ❑ D ❑ W

Mailing Address_____

City, State, Zip Code_____

2. **Communication Preferences** We may need to communicate with you regarding your medical care. (Required)

Communication Method	Phone Number	Can we leave a message?	Can we send appointment reminder postcards?
Home Phone	( ) -	❑ Yes ❑ No	❑ Yes ❑ No
Work Phone	( ) -	❑ Yes ❑ No	
Mobile Phone	( ) -	❑ Yes ❑ No	

Who can we speak with regarding your medical condition? If patient is under 18 years old, list both parents /guardians.

Full Name	Relationship	Date of Birth	Sex	Emergency Contact	Discuss Medical Condition	Patient Portal Access
		/ /	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Address:	City:		State:		Zip code:	
Phone Number: ( ) -	Email:					
		/ /	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Address:	City:		State:		Zip code:	
Phone Number: ( ) -	Email:					

❑ No emergency contact ❑ No discussion of my medical condition with others ❑ No patient portal access for others

I have been advised of the practice's 'Notice of Privacy Practices'. Initials_____ Date_____

3. **Participate in Your Care Through Our Patient Portal** (Required)

By listing my email address, I will receive a **one-time** instructional email giving me online access to all my visits and will be able to securely message with SDA. ***Without an email address, existing users will no longer receive access to their visits. SDA will only use my email address to give me access to my visits.***

Initials _____ ❑ Yes, I give my email address below for patient portal access ❑ No patient portal

Email Address:_____

4. **Please help us comply with federal requirements by answering the following:** (Required)

Primary Care Physician_____

What is your race? (One or more categories may be selected) ❑ American Indian or Alaska Native ❑ Asian

❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Declined to specify

Preferred Language_____Are you Hispanic, Latino/a, or Spanish origin? ❑ Yes ❑ No ❑ Decline to Specify

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5. Insurance Information (Required)

	Insurance Name	Subscriber's Relationship to Patient	TriWest/TRICARE Sponsor's SSN
Primary			- -
Secondary			- -

Initials _____ ❑ Yes, the patient is self-pay and understands that payment is required at time of service.

6. Treatment of Minors (Required for Patients Under 18 years Old Only)

Patients under 18 years old must have an adult listed below who is financially responsible for any balance once insurance is billed:

	Full Name(s)	Relationship	Sex	Date of Birth	Phone Number
Responsible Person			❑ M ❑ F	/ /	( ) -

Address: City: State: Zip Code:

For many families it is difficult to accompany a minor on every visit, however we can only offer treatment with prior authorization in the absence of the parent or legal guardian.

❑ Yes, I, _____, the parent or legal guardian of the aforementioned minor patient give my permission to Solano Dermatology Associates to provide treatment in my absence.

Parent/Legal Guardian Signature: _____Date:_____

7. Financial Policies (Required)

We are committed to providing you and your family the best possible care. In order to achieve this, we ask for your cooperation with our payment policy. Please read over the details of this form carefully. Complying with the information below will help us in billing your insurance claims.

- We will scan your current insurance ID card(s) and some form of photo ID into your file.
- If your insurance requires a referral, it is your responsibility to get a referral from your primary care physician to our office prior to your appointment.
- **As a courtesy, we will bill your insurance. You are responsible for meeting all deductibles and/or co-insurance amounts required by your policy. If you do not have insurance, payment is due at time of service.**
- Your insurance is a contract between you, your employer, and your insurance company.
- It is your responsibility to inform us of any changes in your insurance coverage, employment or address.
- We will file Medicare and a secondary or supplemental policy. You will receive a bill for any amount approved by Medicare but not paid by your secondary plan.
- If you do not have your insurance card or if insurance cannot be verified before you check out, you are required to sign a waiver stating you understand that you, personally, are responsible for the balance.
- Payment for cosmetic products and/or procedures is required in full at the time services are rendered.
- Services deemed cosmetic/not medically necessary by insurance company are the responsibility of the patient.
- It is the policy of this office that the *adult presenting the child for treatment* is responsible for payment of the patient portion at the time of service.
- Patch testing usually requires a co-pay for each visit of the test, which is normally 3 visits. Please confirm that your insurance company covers this procedure as not all do.
- If liquid nitrogen (often called freezing) is used as a treatment, codes used are considered a surgical procedure by insurance, and must be billed as such.
- Patient balances over 60 days will be subject to a 1.5% monthly finance charge.
- We do not offer professional courtesy discounts.
- If a biopsy is done, you will receive a *separate charge* for pathology reading by: Solano Dermatology Associates (John Geisse, MD)

I have read and understand this financial policy and agree to abide by the terms and expectations listed above.

Patient/Responsible Party Signature:_____Date: _____