Bay Oaks
DERMATOLOGY

Please give your insurance card(s) and drivers license to the front office staff upon check-in. A copy will be made and included with your records.

I give my permission to the staff at Bay Oaks Dermatology to leave messages concerning lab work, biopsy results, medications or any other medical information related to my condition or to discuss my condition with the following:

_____ **Home answering machine. Telephone #_____**

_____ **Work answering machine. Telephone #_____**

_____ **Secretary. Telephone #_____**

_____ **Family member (spouse, children, parents, brothers, sisters).**

Contact Name _____Telephone #_____

Contact Name _____Telephone #_____

Telephone #_____

_____ **Cell phone voicemail. Telephone #_____**

_____ **Send a summary to referring doctor.**

_____ **Send a summary to primary care doctor.**

Date: _____

Printed Name: _____

Signature: _____

I do not give my permission to the staff at Bay Oaks Dermatology to release any medical information related to my condition unless it is to me directly. I can be reached at the following number(s):

Telephone #_____ **Date: _____**

_____ **Printed Name: _____**

_____ **Signature: _____**

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PATIENT INFORMATION

Name: _____

Patient Address: _____

_____

Phone: _____ [ ]Home [ ]Work [ ]Cell

Phone: _____ [ ]Home [ ]Work [ ]Cell

Date of Birth: _____

Social Security: _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT

_____Date of Birth:_____

Relationship to Patient: _____

Guarantor Address: _____

_____

_____

Email: _____

FOR INFORMATION ON OFFICE SPECIALS AND NEWSLETTERS

(Email will not be shared)

PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____

Address: _____

_____

Permission to send a summary [ ]Yes [ ]No

REFERRING PHYSICIAN

Name: _____

Phone: _____

Address: _____

_____

Permission to send a summary [ ]Yes [ ]No

PERMISSION TO TREAT MINOR

I hereby grant Dr. Shelley Sekula Gibbs and staff permission to treat my child when they arrive at the office unaccompanied, for a period of one year.

_____ _____

Signature of Legal Guardian Date

I have reviewed the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future.

_____ _____

Signature of patient or guardian Date

In order to establish optimal relations with our patients and avoid misunderstanding, the following payment policies are in place: **PRIVATE PAY PATIENTS ARE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE. PATIENTS WITH MEDICARE, OTHER INSURANCES ACCEPTED BY OUR OFFICE OR CARE CREDIT, WILL BE RESPONSIBLE FOR THEIR CONTRACTUAL OBLIGATIONS, BE IT CO-PAY OR DEDUCTIBLE. WE ACCEPT VISA, MASTERCARD, DISCOVER, CARE CREDIT, CASH AND CHECK. THERE IS A $25 FEE FOR ALL MISSED OFFICE VISITS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT.** Your signature below indicates that you understand and accept this policy. Your signature also authorizes the doctor to release medical information/records. You herein authorize payment of medical benefits to the doctor when a claim is filed by this office. I understand that if services or charges are not covered by insurance, or if we are unable to verify insurance, I will be responsible for all charges incurred for services rendered.

_____ _____

Signature of patient or guardian Date

(Optional) I hereby authorize any physician in this office to use photographs or slides of me for educational or research purposes.

_____ _____

Signature of patient or guardian Date