

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 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, OR 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. WE HAVE A \$25 FEE FOR ALL MISSED OFFICE VISITS THAT ARE 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, if requested, to your primary care or referring physician, to your insurance company to process an insurance claim, or for the purpose of healthcare operations. You herein authorize payment of medical benefits to the Doctor when a claim is filed by this office. I understand that if any of the services or charges are not covered by insurance, or if Shelley Sekula Gibbs, M.D. is unable to verify insurance, that I am 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