

# Bay Oaks

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## DERMATOLOGY

### PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other

Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other

Email Address (optional) \_\_\_\_\_

### PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

### NAME OF PERSON RESPONSIBLE FOR PAYMENT

\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Billing Address:

\_\_\_\_\_

Patient ID#: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security #: \_\_\_\_\_

Drivers License \_\_\_\_\_

### CONTACTS

I hereby give consent to Shelley Sekula Gibbs, M.D. to release information concerning my medical condition & treatment to the following:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

### PRIMARY CARE PHYSICIAN

Name \_\_\_\_\_ Phone \_\_\_\_\_

***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 regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **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, CASH OR CHECK.** 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

*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 with the following:**

\_\_\_\_\_ Home answering machine. Telephone # \_\_\_\_\_

\_\_\_\_\_ Work answering machine. Telephone # \_\_\_\_\_

\_\_\_\_\_ Secretary. Telephone # \_\_\_\_\_

\_\_\_\_\_ Family member (spouse, children, parents, brothers, sisters).

Telephone # \_\_\_\_\_

\_\_\_\_\_ Cell phone voicemail. Telephone # \_\_\_\_\_

**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:** \_\_\_\_\_