Northstar Dermatology Annual Patient Information Form

Patient Name: _____ **Date of Birth**: _____ / _____ / _____

Please inform our receptionist of any changes to your address, phone number(s), or insurance since your last appointment.

_____

Emergency Contact Name | Relationship to Patient | Phone Number

_____

Primary Care Physician | City, State

Authorized Person(s) to Receive Information: I authorize Northstar Dermatology to release medical, appointment, and/or financial information over the phone or in person to the following person(s) (i.e. spouse, family member, etc.):

Name | Relationship to Patient | Phone Number

1.) _____

2.) _____

May We Contact You by Phone and Leave a Message About Your Care or Regarding Lab/Pathology Results?

☐ Leave a detailed message on voicemail/answering machine. Phone #: _____

☐ Leave a message with authorized individual answering the phone.

☐ Please do not leave a detailed voicemail; leave message with call back number only.

Missed Appointment Policy. We require 24-hour advanced notice if you are unable to keep a scheduled appointment. It is our policy that a single missed appointment will require a $50 deposit to book any future appointments.

Medication Compliance Policy. Under no circumstance will medications (antibiotics included) be refilled for missed or cancelled appointments.

Consent for Treatment: I consent to and authorize the physician(s) and employees at Northstar Dermatology to render care to me during my office visit(s). I authorize the release of my medical information to my primary care physician, referring physician, and/or consultants as necessary to carry out treatment and to process insurance claims and/or prescriptions. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize taking photographs at the discretion of the provider, solely for documentation purposes, and recognize they will be kept confidential unless otherwise disclosed.

Assignment of Benefits: In consideration of services rendered or to be rendered, I assign and transfer to Northstar Dermatology any benefits payable to me or on my behalf under any insurance coverage. I understand it is my responsibility to provide current insurance information prior to treatment. I understand that I am financially responsible for services provided which are to be paid on the date of service. I also acknowledge that the filing of an insurance claim(s) is not a guarantee of payment, and that I am financially responsible for payment if such claim(s) are unpaid or denied by the insurance company. I have received a copy of the "Office Financial Policies" and agree to comply with such policies.

I have read and understand the above, consent to treatment, and agree to comply with the policies of Northstar Dermatology.

Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____ Date: _____