FAIRLAWN DERMATOLOGY, LLC

Date________/________/________

**************************************PEDIATRIC PATIENT INFORMATION**

CHILD:

Name____ _______ ____
First M.I. Last

Address____ ______________________________________ ______ ________________
Street City State Zip

Home Phone ( ) ___________________________ Birthdate ___________________________________

Social Security Number__________/__________/__________________ Gender: ( ) Female ( ) Male

Race: White___ Black/African American___ American Indian/Alaska Native___ Asian___ Native Hawaiian/Other Pacific Islander___ Other____

Ethnicity: Spanish/Hispanic Origin ___ Not of Spanish/Hispanic Origin ___

Primary Language: ____ Secondary Language: ____

Local Pharmacy Name _________________________ Pharmacy Location_______________________ Pharmacy Phone ( ) ______________________

Mail-Order Pharmacy ____

Primary Care Physician____ Primary Care Physician's Phone ( ) _____________________________________

Referring Physician____ Referring Physician's Phone ( ) ____

MOTHER:

Name____ _______ ____
First M.I. Last

Address____ _______________________________ ____________ ____________________
Street City State Zip

Social Security Number__________/__________/__________________ Date of Birth __________/___________/__________________________

Home Phone ( ) _____________________________ Cell Phone ( ) ____

E-mail Address ____

Employer Name____ Work Phone ( ) ____________________________________

FATHER:

Name____ _________ ____
First M.I. Last

Address: ____ ________________________________ _________ _____________________
Street City State Zip

Social Security Number ________/__________/______________ Date of Birth _______/_________/_____________

Home Phone ( ) _____________________________ Cell Phone ( ) ______________________________________

E-Mail Address ____

Employer Name____ Work Phone ( ) ____________________________

PLEASE GIVE YOUR INSURANCE CARD(S) TO RECEPTIONIST FOR SCANNING. THANK YOU.

****** PLEASE CONTINUE TO BACK PAGE ******

************************************ MISCELLANEOUS INFORMATION ************************************

1) How were you introduced to our practice, if other than by a physician? ____

2) Kindly identify your nearest relative or emergency contact:

Name______________________________ _______ _______ ______________________________
First M.I. Last

Relationship______________________________ Phone (   ) ______________________________

*** FINANCIAL POLICY ***

It is our hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources required to maintain vital health care service for all of our patients. If you have health insurance, please understand that this is an agreement only between you and your insurance company. Your physician's bill is an agreement between you and your physician. Payment of your co-payment, co-insurance and deductible are required at the time of the service. For your convenience we accept Mastercard and VISA. As a further service, we will submit your charges to your insurance company for you, if you provide us with the current and complete insurance information. It is your responsibility to be familiar with your insurance policy and what it covers. If your insurance policy requires a referral or authorization for testing or special procedures, please let us know when you make an appointment. Failure to do so may result in your full responsibility for payment of services. If you do not have insurance coverage, payment at the time of service is required. Should surgery be appropriate, payment of one half of the projected surgery fee prior to surgery will be necessary. Payment for the balance can be arranged with our billing department. If unusual circumstances should make it impossible for you to meet our credit terms, we encourage you to let us know. Accounts over 90 days are referred to an outside agency for collection, which could affect your credit rating for seven years. If your account is turned over to our collection agency, you will be dismissed from our practice. Emergency treatment will be provided for 30 days from the dismissal letter. If your treatment is the result of an accident and a lawsuit or hearing is involved, payment for this treatment must either be processed through your health insurance or payment made at the time of service. We will assist your attorney with copies of records and billings as appropriate.

********* AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS & INFORMATION RELEASE *********

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician of Fairlawn Dermatology and authorize payment directly to the physician of the Medical and/or Surgical benefits, if any, otherwise payable to me by Medicare or any other insurance company, for her services, and I assume responsibility for any unpaid balance including non-covered services except as limited by law. I also hereby authorize the physician to release any information to Health Care Financing Agency, or its agents, to third party payors and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney, consultants, and to my insurance company as acquired in the course of my examination or treatment. This authorization will remain in effect until revoked by me in writing.

I have reviewed and accepted the above Financial Policy and Authorization, Assignment and Information Release.

____ ______________________
Signature of Patient or Responsible Party Date

____
Print Name

How would you like appointment confirmations sent? Check all that apply: Home Phone __ Cell Phone __ Text Message __

How would you like results given? Check all that apply: Home Phone __ Cell Phone __

Person responsible for billing: ____

Is there anyone other than the parent(s) that should be allowed to receive medical information?

☐ Legal guardian ______________________________ ______________________________
Name of person Phone Number

☐ Grandparent(s) ______________________________ ______________________________
Name of person Phone Number

☐ Other ______________________________ ______________________________
Name of person Phone Number

This authorization will remain in effect until revoked by me in writing.

______________________________ ______________________
Signature Date