BEAIRD dermatology

Patient Information

Patient's First and Last Name:	Prefix:	Nickname:	Date of Birth: (mm/dd/yyyy)
Status: (please circle one) Single Married Divorced Widowed Partner	Sex:	Occupation:	Student: (please circle) Yes No

Home Phone:	Cell Phone:	Work Phone:	Preferred Phone: Home Cell Work	May We Leave a Message? Yes No

Street Address:	City/State:	Zip Code:

Email Address:	Patient Employer:

Primary Care Physician:	Referring Doctor: (if different from primary)	How Did You Hear About Us?

Emergency Contact:

First and Last Name:	Relationship:	Phone Number:

Do you give our office permission to discuss your medical information with your emergency contact? (please circle) Yes No

Parent, Spouse, or Legal Guardian:

First and Last Name:	Phone Number:	Address/City/State/Zip Code:

Cancellation and No-Show Policy: If you are unable to keep an appointment for any reason, we ask that you kindly provide us with a minimum of 24-hour notice. If you are unable to give a notice, you will incur a no-show or last-minute cancellation fee of $50 for general dermatology, $75 for any aesthetic appointment, or $100 for injectable appointments.

Late Arrival: We understand that delays can happen, however, we must try and keep the other patients and our providers on time. If you do not contact us advising us that you are delayed or have received a verbal "okay" and are here 10 minutes past your scheduled appointment time, we may have to reschedule your appointment.

Insurance Authorization and Assignment: I hereby authorize Beaird Dermatology, S.C. to furnish information to my insurance carriers concerning my diagnosis and treatments, and I assign to Beaird Dermatology, S.C. all payments due for services rendered to myself or my dependents, if I do not make payments in full for such services. In addition, I agree to pay all applicable copayments and deductables at the time of service.

Financial Policy: Beaird Dermatology has contracts with many insurance plans. Due to the numerous healthcare plans available, it is the patient's responsibility to verify that we are in network with your specific insurance plan. You will be responsible for any copayments, deductibles, purchased prodcuts, and/or non-covered services. If you do not have one of the plans with which we are contracted, the total cost of your visit is required at the time of service. Payment methods include: cash, personal checks, Visa, Mastercard, Discover, American Express, and Care Credit.

Acknowledgement of Review and/or Request of HIPAA Policies: Under the Federal HIPPA laws, we are mandated to provide our patients with a copy of our Patient Privacy Policies. The notice provides detailed information about how Beaird Dermatology, S.C. may use and disclose my confidential information. I understand that Beaird Dermatology, S.C. has the right to change his or her privacy practices that are described in the notice and a revised notice will be provided to me upon request. Your signature is your acknowledgement that you have either received or were offered a copy today and that you have reviewed this form of our policies.

Signature of Patient or Guardian **Print Name** **Date**