

Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address(if different from above): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F SS#: \_\_\_\_\_ Marital Status: S M D W O

Home Phone:( ) \_\_\_\_\_ Contact Person and Phone#: ( ) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone#: ( ) \_\_\_\_\_ ext. \_\_\_\_\_

Parent's employer if patient is a minor.

Referring Doctor: \_\_\_\_\_ N/A

I am the Parent/Legal Guardian (if patient is under 18) and I approve any future treatments without my presence.

Signature \_\_\_\_\_

I authorize DAK to call me at the following number(s) other than those listed above, regarding any aspect of my care.( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

I authorize DAK to speak with the following designated person(s) regarding any aspect of my care, including appointments, test results, etc.: \_\_\_\_\_

Name

Name

No Insurance/ Self Pay

Primary Insurance Co. : \_\_\_\_\_

If the person who carries the insurance coverage is different from the patient, complete the following:

Policy Holder's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Sex: M F

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_ Phone# : \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Phone# : \_\_\_\_\_

Secondary Insurance Co. : \_\_\_\_\_

If the person who carries the insurance coverage is different from the patient, complete the following:

Policy Holder's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Sex: M F

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_ Phone# : \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Phone# : \_\_\_\_\_

**Medicare Patients:** We are required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim.

*I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.*

Signature as it appears on Medicare card: \_\_\_\_\_ Date: \_\_\_\_\_

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file. *I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.*

Signature as it appears on Medigap card: \_\_\_\_\_ Date: \_\_\_\_\_

I have been informed of the financial policy of this facility. I understand if my account becomes delinquent and turned over to a collection agency, I will be responsible for all fees and/or legal expenses incurred. A copy of the Financial Policy and the Notice of Privacy Practices are available upon my request.

Print Patient Name

Responsible Party Signature

**All pathology specimens are sent to a laboratory for analysis and the laboratory will bill separately for this service. It is your responsibility to inform the physician or nurse if your insurance requires us to use a specific lab.**

**Dermatology Associates of Knoxville, PC**  
**Patient Authorization and Financial Agreement**

The staff of Dermatology Associates of Knoxville, PC is committed to providing quality care. If you have medical insurance, we want to help you receive your maximum allowable benefits. We will be happy to process your insurance claim. In order to achieve this we need your assistance and understanding of our financial policy.

**Release of Information:**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

**Payment Policy:**

**Medicare:** We are participating providers of the Medicare program. Patients are responsible for meeting their annual deductible and co-payments. We do file secondary carriers, however, in the event the secondary does not pay, patients will be billed the balance.

**HMO, PPO or other managed care patients:** You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services before receiving services. I understand if I do not have a referral for any visit, I will be expected to reschedule my appointment.

**Commercial Patients:** If you are covered by private, commercial plans in which our physicians are not providers, you will be responsible for the entire balance left after payment from your insurance carrier regardless of the benefits and payment policies of your carrier.

**Self-Pay Patients:** You are required to pay at the time of service. We accept cash, checks, VISA, Master Card, and Discover.