Lakes Dermatology & Laser Center

2021 Patient Information Sheet

THE SPA AT LAKES DERMATOLOGY

PATIENT INFORMATION

Date_____

Patient Name_____
Last Name

_____
First Name Middle Initial

SS #_____

Address_____ Apt. #_____

_____
City State Zip

Email address_____

Would you like to receive specials via email? Y N

Sex ☐ M ☐ F ☐ X Birthdate____/____/_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Minor ☐ Domestic Partner ☐ Separated

Responsible Party_____

Profession_____

Patient Employer_____

Employer Address_____

_____

Employer Phone (____)_____

MEDICAL HISTORY INFORMATION

Medications Please list any medications you are currently taking OR do you give us permission to access your pharmacy's medication list for you Y N

_____

_____

_____

_____

_____

Allergies (List any known allergies, including medication, food, environmental)_____

_____

_____

_____

_____

_____

Known Illnesses/Diseases/Major Surgeries/ Pacemakers/Organ Transplants or Other Foreign Bodies_____

_____

_____

_____

Pharmacy Contact Name, Address, Phone Number_____

_____

PHONE NUMBERS

BEST contact # (____)_____ **Can we leave a message at this number?** Y N

Can we TEXT to this number? Y N

Additional # (____)_____ Can we leave a message at this number? Y N

Emergency Contact Name_____

Emergency Contact Phone (____)_____

REFERRALS

The greatest compliment we receive from our patients is the referral of your friends and family.

Whom may we thank for referring you?_____

Remember—cosmetic referrals can get you a $25.00 gift certificate to use at an upcoming cosmetic appointment or for products!

SEE REVERSE

Lakes Dermatology & Laser Center

2021 Patient Signatures

THE SPA AT LAKES DERMATOLOGY

No-Show and Cancellation Policy

Our offices require 24 hour notice if you are unable to make your appointment. Courtesy reminder calls and/or texts are attempted 24-48 hours before your appointment. **If you do not comply with the 24 hour notice, we will bill you a minimum of a $50 fee for the date of service missed. Longer services or surgeries may have additional fees.** Payment on this charge is required before making future appointments.

_____ Date _____/_____/_____

Patient (or Guardian) Signature

HIPAA Compliance

A Notice of Privacy Practices is available. Please ask for a copy so that you may review the policy and understand your rights and our compliance. Please sign below that you acknowledge our compliance.

_____ Date _____/_____/_____

Patient (or Guardian) Signature

Financial Payment Agreement

The financial payment policies of this office include:

- Whether you belong to an insurance plan or we are not a provider within your insurance network, you are responsible for all charges. Applicable co-payments will be collected at the time of your visit; deductibles and co-insurance payments will be billed to you. Sometimes your insurance company may remit a check payment directly to you for services rendered by us—this depends on your insurance plan—but these monies are due to us and will be billed accordingly.
- For cosmetic procedures, all payments are expected at the time of service, unless other arrangements have been made prior to treatment. We do not send bills for cosmetic procedures, nor do we put balances “on account”. If you are purchasing a package treatment series, payment arrangements will be discussed with you and agreed upon prior to beginning treatment. You will also be required to sign consents for any cosmetic procedures.
- Certain medical procedures may require us to send tissue or specimens to a lab. The lab coordinates care with us but they will bill you separately for these charges. We do not control their charges or have any ability to work with them in regard to your payments.
- We accept payment in the form of cash, check, Care Credit, or credit card (Visa, Mastercard, Discover, and American Express). We do not hold checks. A $25.00 NSF fee will be charged for returned checks and your account will be turned over to the District Attorney and/or our collection agency in the event of an NSF check as well.
- We have an agreement with Transworld GreenFlag Collections Agency regarding accounts that do not pay in a timely manner. We will send statements before sending your account to collections – if you provide an email address we will also send you an email as a final reminder. In the event your account is sent to Transworld, a fee of $15.00 *minimum* will be added to your account and due by you along with the fees which you owe for your services. Our goal is never to send anyone to collections. Please help us to do this by contacting our office if you are unable to pay your bill for any reason so we can discuss options with you.

By signing below, I acknowledge that I understand the financial terms described above and agree to adhere to these.

_____ Date _____/_____/_____

Patient (or Guardian) Signature