LEVY DERMATOLOGY

Please print and answer all questions in full.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of Birth: _____ SS#:_____

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Occupation: _____ Employer: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Insurance Responsibility Is Insurance Policy Holder the patient? **No Yes**

If yes, move onto next section. If no, please answer the following questions.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ City: _____ Zip: _____

Contact Number: _____ Date of Birth: _____

Employer: _____ Sex: Male Female

Referring Physician Information (If applicable)

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Preferred Pharmacy: _____

How did you hear about us: Family/Friend If so, who?:_____

Internet Search Social Media Online Reviews Other:_____

Office Policy

Please remember that insurance is considered a method of reimbursing the patient for fees paid to Levy Dermatology, P.C. and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. In order to control the cost of billings, we request that charges be paid at the conclusion of each visit. I am aware that my insurance ***copay, deductible, and/or coinsurance*** is to be paid at each date of service. If my insurance plan requires an authorization for this visit and any follow up visits, it is my responsibility to ensure that the ***referral*** is current and on file with Levy Dermatology, P.C. ***IT IS MY RESPONSIBILITY TO PAY ANY COPAY, DEDUCTIBLE, COINSURANCE, AND/OR OTHER BALANCES NOT PAID BY MY INSURANCE COMPANY.*** I am aware that if Levy Dermatology, P.C. does not participate with my plan or if I have no insurance, payment in full must be made on the date of service.

Patient/Legal Guardian Signature: _____ Date: _____

East Memphis
6254 Poplar Avenue
Memphis, TN 38119
Fax: (901) 624- 1203

Collierville
1125 Schilling Blvd. E. Suite 105
Collierville, TN 38017
Fax: (901) 457-7407

Cosmetic Center
6252 Poplar Avenue
Memphis, TN 38119
Fax: (901) 624-1203

Jackson
158 Murray Guard Dr.
Jackson, TN 38035
Fax: (731) 240-1415

Levy Dermatology, P.C.
Patient Financial Policy

In order to provide understanding between our patients and the practice, we have implemented the following financial policy. If you have any questions about the policy, please ask to speak with someone in our billing department. We are committed to providing you the best possible care and your complete understanding of your responsibilities are a key element in providing that service.

- A driver's license, or other state-issued photo ID, is required to be shown at your visit to verify that we are providing services to the appropriate person and protect our patients from identity theft.
- For all services rendered to minor patients, we will hold the parent or legal guardian accompanying the minor on the first visit responsible for the expenses occurred.
- If you fail to notify us of an insurance change you will be **fully responsible** for any amount not paid by your insurance company.
- Commonly, in this practice, we perform surgical procedures that require lab work. The laboratory company will bill your insurance and a ***separate statement*** will be sent to you for their services.
- Past due accounts may be referred to a collection agency. Additional fees may be incurred when accounts are sent to collections, and you may be reported to credit reporting agencies. Offices visits are at risk of being terminated when non-payment is a persistent issue.
- Out of courtesy to others, we ask that you kindly give at least a 24-hour notice for cancelling an appointment. You will be responsible for a **$35 charge** for general appointments and an **$80 charge** for surgeries and/or cosmetics for no-show visits or cancellations less than 24-hour notice.
- **Cosmetic appointments/concerns are subject to an $80 consultation fee**. All payments towards cosmetic appointments are due at the time of service.

Patients Filing with Insurance (General Dermatology/Surgery Patients ONLY):

- Knowing about your insurance coverage is your responsibility and you may contact the insurer for coverage questions. ***It is always best to ask questions about your insurance coverage PRIOR to having services performed.***
- Co-pays, deductibles, and coinsurances are required at the time of service. We accept cash, credit, debit, and care credit.
- You are responsible for any services that your insurance does not cover at the time of service.
- As a courtesy, we will file an insurance claim with your insurance company. If your insurance company has not paid the claim within 45 days you will be responsible for payment.
- Your insurance policy is a contract between you and your insurance company in which the doctor is not involved.
- Note: Even though a service is "covered" by your insurance policy, this does not necessarily mean that your insurance will pay for the service. If you are unsure of your responsibility, please contact your insurance company *prior* to your visit or having any procedures done.
- If any claim is not covered after processing through your insurance company, you are responsible for the unpaid balance.

Patients with Insurances we DO NOT participate with and/or Self-Pay Patients (General Dermatology/Surgery ONLY):

- Payment in full is required at the time of service. We accept cash, credit, debit, or care credit.
- If you have received authorization for services from our practice that are not normally covered by your plan, please note that payment is still due at time of service, and we will file a courtesy claim for you.

I have read and understand the financial policy of Levy Dermatology, P.C. and agree to its terms. I understand that such terms may be amended by the practice at any time.

Patient Signature or Responsible Party if Minor **Date**

Printed Name of Patient: _____

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Levy Dermatology, PC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Levy Dermatology, PC has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Levy Dermatology, PC will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Levy Dermatology, PC to use and disclose my protected health information to carry out treatment, payment, and health care operations. My signature below acknowledges that I understand that this consent will serve as my consent for ALL future visits with Levy Dermatology, PC, unless revoked by me in writing. I have the right to revoke this consent in writing at any time, except to the extent that Levy Dermatology, PC has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Levy Dermatology, PC. Phone: (901) 624-3333

East Memphis	Collierville	Cosmetic Center	Jackson
6254 Poplar Avenue	1125 Schilling Blvd. E. Suite 105	6252 Poplar Avenue	158 Murray Guard Dr.
Memphis, TN 38119	Collierville, TN 38017	Memphis, TN 38119	Jackson, TN 38035
Fax: (901) 624- 1203	Fax: (901) 457-7407	Fax: (901) 624-1203	Fax: (731) 240-1415

FORM Us

Levy Dermatology
Medical/Surgical/Cosmetic Skin Care Specialists

Patient Name: _____ Date of Birth:_____

CONSENT FOR CARE
I hereby give by consent for treatment at Levy Dermatology, P.C.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Levy Dermatology, P.C. to release any information acquired during my examination or treatment to third party payors for payment of the charges. I authorize the release of any information necessary to expedite insurance claims.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed 2013.

ELECTRONIC PRESCRIBING
I authorize Levy Dermatology, P.C., its employees, or agents, to release Medical Information to share and/or receive prescription information electronically via SureScripts for my treatment medications.

PHOTOGRAPHY
Photographs are often necessary for documentation of medical, surgical, and cosmetic procedures. I understand that the photographs are subject to the same highest level of confidentiality, privacy, and security as my other medical records. By consenting to these medical photographs, I understand that I will not receive payment from any party and that all identifiable features of the photograph will be concealed to the best of our ability.

By checking more than medical chart below, I understand that should my image be selected for publication, the image may be seen by members of the public in addition to students and medical researchers. Every effort to conceal identifiable features of the photo will be made. I understand, however that it is possible that someone may recognize me, and I hold Levy Dermatology and Dr. Levy harmless for any consequences of my identification. I understand that once photographs are released to social media, it is impossible to control them and their use/distribution.

I give my permission for medical photographs to be made of me. I understand that the information may be used in my medical records, for medical teaching purposes, for publication in medical textbooks or journals, and/or in media as I have designated below.

By signing below, I confirm that this consent form has been explained to me in terms that I understand. *I consent for my photographs to be used for (Please place a check mark in EACH BOX indicating your consent*):

X My medical chart only (required)
_____ Medical teaching purposes
_____ Patient information, website, before and after's, advertising

Authorization to Leave Messages
Please place a check mark in EACH BOX indicating your consent:
_____ I hereby authorize Levy Dermatology, P.C. to leave a voicemail regarding appointments, tests, or other information at my residence or cell phone.
_____ I hereby authorize Levy Dermatology, P.C. to send appointment reminders or other information via text message. I understand charges from my carrier may apply.
_____ I hereby authorize Levy Dermatology, P.C. to send me information via email.

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical record.

Name _____Relationship _____Phone Number_____

Name _____Relationship _____Phone Number_____

By signing below, I understand that this consent will serve as my consent for ALL future visits at Levy Dermatology, PC, unless revoked by me in writing. I may revoke this authorization at any time by notifying the clinic in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

_____

Patient or Parent Signature **Relationship** **Date**