

Patient Name: _____
(Last) (First) (Middle)

Address: _____
(Street, PO Box, apt #)

(City) (State) (Zip Code)
Home Phone : () _____ Work Phone: () _____

Cell phone or pager: () _____

Date of Birth: _____ Social Security # _____

Driver's License: State: _____ # _____
Sex (Circle): Male / Female Marital status: _____

Primary Care Physician: _____

How did you hear about us?

Referring Physician: _____ Internet Search / Website

Friend/Family If yes, please list name _____

Insurance Advertisement (which one?) _____

Emergency Contact:

Name and Relation: _____

Home phone () _____ Work phone () _____

Address _____

Contracted Insurance Patients: BCBS, Medicare, Humana Medicare Advantage &

Tricare Standard Plan Information: Please give your CURRENT insurance card(s) & photo ID to the front desk and fill out the following information.

___ Medicare only ___ Medicare with secondary insurance _____

___ Medicare Advantage Plan _____

___ Blue Cross Blue Shield ___ Tricare Standard

Are you the PRIMARY INSURED / POLICY HOLDER?

Yes - please verify the above information is correct and initial here _____

No - answer the following information about the policy holder:

PRIMARY INSURED / POLICY HOLDER INFORMATION:

Name / relation (spouse / parent): _____

Home address: _____

Phone : () _____ Date of birth: _____ Social Security# _____

Occupation: _____ Employer: _____

Fee for Service Patients: Patients with **NO HEALTH INSURANCE** &/ or patients with **OTHER HEALTH INSURANCE** that Dr. Martinez is not a contracted provider with.

_____ I have no medical insurance

_____ I have medical insurance with _____ and Bee Caves Dermatology is not a participating provider with this company.

I understand that I will be required to pay in full for services provided to me by Bee Caves Dermatology at the time of service and that no insurance claim will be filed for me by Bee Caves Dermatology. I understand that I will be given a copy of the encounter form, and that I may file my own claim with my insurance company for potential reimbursement / credit for out of network deductibles for medical, non-cosmetic expenses only. I understand that Bee Caves Dermatology can make no estimate or guarantee as to what amount if any my insurance company may reimburse me. I understand that if I choose to supply Bee Caves Dermatology with my insurance information, this information may be entered for me for the purposes of non-cosmetic outside laboratory and pathology fees. However, Bee Caves Dermatology cannot be held responsible for those outside independent charges and cannot guarantee that my insurance company will cover those expenses.

X

Signature and date

Acknowledgement of Review of Notice of Privacy Practices (HIPAA):
(The Privacy Notice can be reviewed on our website
www.beecavesdermatology.com or upon check in at the office a copy
can be made available to you)

I have been given the opportunity to review Bee Caves Dermatology Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices if I desire. I understand that if I want to be seen as a patient by Dr. Martinez and her associates that this acknowledgement must be signed as required by law.

Signature _____

Date _____

(Patient or Personal Representative, if the patient is a minor or unable to sign themselves)

Office Policies: Please Read and Initial

_____ **Cancellation Notice: If you need to cancel an appointment, we require 24 hour notice. If you do not give 24 hour notice, you will automatically receive a \$30.00 missed appointment fee. There are no exceptions to this policy, it helps us to see our patients when they need and want to be seen.**

_____ **Failure to keep scheduled appointments “No Shows”: If you miss an appointment, you will receive a \$30.00 missed appointment fee. If you miss 2 or more appointments without prior notification, the office will no longer schedule you appointments.**

_____ Minor patients: A minor must be accompanied by parent or legal guardian or Bee Caves Dermatology must have written consent to see the unaccompanied minor. A minor consent form is available on our website, www.beecavesdermatology.com

_____ Late to appointments: If you are late for an appointment, you may be asked to reschedule or you may be asked to wait to be seen until all other patients that are on time are seen first. If you are late to 3 appointments the office may not schedule you any additional appointments.

_____ Prescription Refills: Please contact your pharmacy to initiate a refill on your prescription. The pharmacy will send a fax with all of the current prescription information for Dr. Martinez to approve or deny. Regular follow up appointments must be kept in order to maintain your current medications.

_____ Financial policy for patients with Medicare, BCBS, Medicare Advantage Plans & Tricare Standard: **If you have Medicare and a secondary, Medicare only, or non-Medicare primary insurance that we are a contracted provider for – we will file your claim. However, if payment is not received from your insurance company, you are ultimately responsible for any charges and you will be sent a bill for the charges. Patient statements are sent out monthly. Payment is due when you receive your statement. If no payment is received within 60 days, your account will be automatically turned over to a collection agency. If your insurance company is requesting information from you to process your claim please contact them immediately to avoid your account being turned over to collections.**

_____ Co-Pays and Deductible amounts are due in full at the time of service. Insurance deductibles and co-pays are full responsibility of the patient. Please check with your insurance plan for your personal deductible and surgical deductible amount. Dr. Martinez is a specialist and may have higher co-pays than your primary care doctor.

I have read and understand the above office policies and agree with their terms. I understand that I have provided all appropriate insurance information, if Bee Caves Dermatology is filing my insurance. I understand that I am ultimately responsible for all charges whether paid for by insurance or not.

Signature _____ **Date** _____
Revised 2/2012 BCD

