DERMATOLOGY OFFICE
ELLEN TURNER M.D.

4301 N Mac Arthur Suite 201
Irving, TX 75038

214-373-7546

8222 Douglas Ave Suite 950
Dallas, TX 75225

Last Name	First Name	MI	Maiden
Address	City	State	ZIP
Phone #	Cell #	Work #	
Preferred method of confirmations:	**□ TEXT**	**□ CALL (circle morning, afternoon or evening)**	
SS#	Sex □ M □ F	Date of Birth	
Marital Status	□ Married □ Divorced □ Single □ Widowed		
Email Address		Driver's License #	
Emergency Contact	Relation	Phone #	

Referral/How did you hear about us?
WHO IS YOUR PRIMARY DOCTOR?
Pharmacy Name Phone #

INSURANCE INFORMATION (Please provide POLICY HOLDER'S information)

Policy Holder Name	Relationship of Patient to Insured	
Insured DOB	SS#	
Employer	Employer Address	
Occupation	Work #	Cell #
Primary Insurance Co		
Secondary Insurance Co		

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

THE UNDERSIGNED AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED FOR MYSELF OR DEPENDENTS AND AGREE THAT MY SIGNATURE BELOW AUTHORIZES CLAIMS SUBMITTED FOR SERVICES RENDERED. I HEREBY AUTHORIZE MY INSURNACE COMPANY TO PAY AND ASSIGN DIRECTLY TO PARK CITIES DERMATOLOGY PA, d/b/a DERMLASER INSTITUTE OF DALLAS ALL REIMBURSEMENT BENEFITS PAYABLE UNDER MY INSURANCE POLICY.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, AND IF MY INSURANCE DOES NOT PAY WITHIN 45 DAYS FROM THE TIME THEY RECEIVE THE CLAIM, THE BALANCE IS DUE FROM ME. IF MY INSURANCE IS AN HMO AND I DO NOT PRESENT A REFERRAL FROM MY PCP AT THE TIME OF SERVICE, I AGREE TO BE RESPONSIBLE FOR CHARGES DENIED BY MY INSURANCE COMPANY DUE TO NON-PRESENTATION OF A REFERRAL FROM MY PCP OR PRE-AUTHORIZATION FROM MY WORKERS COMPENSATION INSURANCE COMPANY (IF I PERSENT AS WORKERS COMPENSATION PATIENT).

I HEREBY AUTHORIZE PARK CITIES DERMATOLOGY PA, d/b/a DERMLASER INSTITUTE OF DALLAS TO RELEASE BY MAIL, TELEPHONE OR FAX ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS.

I CERTIFY THAT THE INFORMATION GIVEN BY ME IS CORRECT. I UNDERSTAND THAT FEES FOR ALL SERVICES PROVIDED BY PARK CITIES DERMATOLOGY PA, d/b/a DERMLASER INSTITUTE OF DALLAS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

X _____

(Authorized signature of Patient, Insured and/or Guardian) (Date)

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FINANCIAL POLICY

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED INCLUDING ANY CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE. WE ACCEPT CASH, CHECKS, MOST MAJOR CREDIT CARDS AND CARE CREDIT.

Prompt Pay: Our office will offer a 20% discount off gross charges if the entire amount is paid in full at the time of service. Payments are due at the time of service. We have a no refund policy on products and cosmetic services.
Initial _____

Insurance: Plan provisions require HMO/PPO patients present a current insurance card at the time of service; otherwise, payment is due in full and no adjustment will be made later. If we are not a participating provider with your insurance plan, a claim will not be filed and full payment is expected at the time service is rendered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within an acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies ONLY to companies that pay a percentage (such as 50% or 80%) of "U.C.R" (usual, customary and reasonable). This statement does not apply to companies that reimburse based on an arbitrary "schedule" or fees, which bear no relationship to the current standard of cost and care in this area.
3. Not all services are covered benefits on all contracts. Some insurance companies arbitrarily select certain services they will not cover. In the event your insurance carrier does not cover your service, you will be responsible for payment of that service and will be billed accordingly.
4. **Unpaid balances over 45 days will be assessed a 1.5% late charge. All outstanding balances over 60 days without prior arrangements will be subject to collection by an outside agency, which may incur additional fees and could adversely affect your credit rating. Initial _____**

We must emphasize that, as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. If the claims are not paid by your insurance company within 45 days after a claim has been received from our office, then the balance will become your responsibility. You should maintain an active role in working with us and your insurance provider to make sure that claims are processed correctly. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

MEDICAL NO-SHOWS: A patient will be considered a "No-Show" and charged $35 if they are more than 15 minutes late for their scheduled appointment time or if they cancel their appointment less than 24 hours prior to their scheduled visit. We understand that appointments can sometimes not be kept. However, we request that if you cannot keep an appointment for any reason, kindly call us at least 24 hours in advance so that someone else may have your appointment time. Many patients need to see a provider as soon as possible, and it is not fair to a patient to be denied treatment because another patient did not call to cancel an appointment in advance. **Initial _____**

SURGERIES: For medical surgeries that are 30 minutes in length or longer, we ask that you leave your credit card on file with the receptionist. If you miss a surgery, arrive more than 15 minutes late or simply choose not to attend it and have NOT called 24 hours prior to the time of the appointment to reschedule, you will be charged $100 for a missed surgery which is non-refundable.
Initial _____

PHOTOGRAPHY CONSENT: I agree to the taking of before and after photographs for any procedure and to confidential review of these photos by my physician. I understand my photos will be used to track my treatment progress and also permit their use for medical publication and teaching purpose, as well as marketing purposes. I hereby authorize Ellen Turner, M.D. and her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes including, but not limited to showing these images on public or commercial television, electronic digital network/websites, or the purpose of patient education, lay education or during a lecture to medical or lay groups. I acknowledge that no guarantee or assurance has been made to me by Dr. Turner or her medical staff regarding the results that may be obtained.

_____ I agree to photography **ONLY** for identification and clinical progression.

_____ I agree to photography **ONLY** for identification and clinical progression and also permit their use for medical publication and teaching purpose, as well as marketing purposes such as use for pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes including, but not limited to showing these images on public or commercial television, electronic digital network/websites.

COSMETIC POLICY AND PROCEDURES

COSMETIC CONSULTATIONS: The fee for all cosmetic and laser consultations with Dr. Turner or a Physician Assistant is $200 and is due at the time of service. Cosmetic consultations with the Medical Assistant or Aesthetician are $ **100**. We require you to hold a credit card on file when scheduling any cosmetic procedures. We also may require prepayment of any cosmetic services or procedures at our discretion. All cosmetic patients must first see an Aesthetician prior to receiving a consultation with Dr. Turner. **Initial _____**

COSMETIC NO-SHOWS: A patient will be considered a "No-Show" if they are more than 15 minutes late for their scheduled appointment time or if they cancel their appointment less than 24 hours prior to their scheduled visit. **They will be charged $100 for each hour of the scheduled appointment.** We understand that appointments can sometimes not be kept. However, we request that if you cannot keep an appointment for any reason, kindly call us at least 24 hours in advance so that someone else may have your appointment time. Many patients would like to be scheduled as soon as possible, and it is not fair to a patient to be denied an appointment because another patient did not call to cancel an appointment in advance. If you miss your appointment for a laser or a cosmetic procedure, arrive more than 15 minutes late, or simply chose not to attend it and have NOT called 24 hours prior to the time of the appointment to reschedule, you will be charged $100 an hour for the missed visit. This will be debited from your credit card on the day of the missed service if you have a credit card on file with us, otherwise you will receive a bill. In addition to being charged a No-Show fee, we may opt to forfeit your treatment if you have purchased a package special**. We do not guarantee you an appointment with a specific provider. Your appointment is for a selected cosmetic service, not an individual. We understand you may prefer a certain provider, but in the event that provider is not here or not able to perform your service when you arrive, we have many fully trained people who could perform your treatment. Should you choose not to get your treatment with someone else, who is available and qualified to perform your treatment when you arrive, you will forfeit that treatment and no refund will be issued for the forfeited treatment**. **Initial _____**

Promotional Prepaid Packages/ Treatments: If you have purchased a package or have any cosmetic services banked, you are required to redeem them within 6 months of the time it was purchased. If you DO NOT have services redeemed within 6 months of purchase they will be forfeited**. Initial___**

Pre Consults: If you have purchased any treatment that requires a pre-consult you must pay for that treatment in full to be scheduled for the treatment. Treatments that require a consultation are very important. **The pre-consult is to ensure we have all policies and procedures in place before your actual treatment is performed**. If you are unable to make it to your scheduled appointment you must call 48 hours prior to reschedule your appointment. **If you do not call to reschedule or "no show" your appointment you will lose 10% of the total cost. You are required to pay the 10% back to get back on the schedule. Initial_____**

Products: We have a no return/no refund policy. If the product you purchased is defective or you have had a reaction to the product we will need to contact the office as soon as possible so that we can address the issue. **Initial_____**

COSMETIC PROCEDURES:

Have you ever had any cosmetic procedures/surgeries performed in the past	**YES**	**NO**
Are you interested in learning more about our cosmetic procedures and services we offer?	**YES**	**NO**

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CREDIT CARD POILICY

To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Copay's due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely,

Ellen Turner, M.D.

COSMETIC PATIENTS: <u>All cosmetic patients are required to have a credit card on file</u>.

I authorize PARK CITIES DERMATOLOGY PA, d/b/a DERMLASER INSTITUTE OF DALLAS, to charge outstanding balances on my account, after all insurance payments and adjustments have been posted, to the following credit card:

Visa MasterCard American Express Other: _____

Name on Card (please Print): _____

Credit Card # _____

Exp: _____ # Digit Security Code: _____

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY POLICY

Please list additional family members/representatives to whom we may disclose confidential information such as biopsy results, lab results, financial information, etc. This authorization will remain in effect unless you specify changes in writing.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

□ **Please check here** if it is ok to leave a brief voice mail message with information that may or may not be confidential if you are unavailable

As required by law, a copy of the office's Notice of Privacy Practices is available to you at the front desk and it explains how medical information will be used and disclosed. By signing below you agree that you understand these practices.

X _____ _____

(Authorized signature of Patient, Insured and/or Guardian) (Date)

Disclosure Notice for Referral of Patient Specimen to Other Participating or Non-Participating Physician Facility
Advocacy for Patient Freedom of Choice for Provider(s)
Other entity: ADG Houston Pathology, PLLC ~ 6633 Portwest Dr., Ste. 100 ~ Houston, TX 77024

In order to better serve you with the highest quality of care and safety at the most affordable costs, sometimes it is necessary and important to have other or additional provider(s) or entities join our team to complete or continue your medical procedures or treatment in order to ensure your speedy recovery. We would like to keep you informed of your choice and our recommendation of these other provider(s) or entities and obtain your informed authorization before our referral and scheduling for your next treatment procedure(s).

While no provider or entity could be participating in every managed care network, such as the one your health plan has contracted with, these other provider(s) or entities may or may not be in your health plan's network. This Form is used to inform you of our verification that the above named provider(s) or entities are either participating or non-participating provider(s) or entities with your health plan. If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider, please call the member services number on your Insurance Identification Card.

Compliance & Disclosure under Texas Occupations Code - Section 102.006
In compliance with Section 102.006 of Texas Occupations Code, in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, Park Cities Dermatology PA d/b/a DermLaser Institute of Dallas has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety. As a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA.

I certify that the Advocacy for Patient Freedom of Choice for Provider(s) with the above specific disclosure from my provider(s) is in full compliance with the Section 102.006 of Texas Occupations Code, in a manner otherwise permitted under Section 102.001, in accepting remuneration to advocate, protect, secure or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.
_____I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.
_____I certify Park Cities Dermatology PA d/b/a DermLaser Institute of Dallas has made referrals to the other participating or non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for this provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expect under my health plan for in and out-of-network coverage.
I have read and fully understand this Disclosure Notice and Authorization Form. I hereby authorize this referral to participating and non-participating and in and out-of-network provider(s) or entities as named above.

Patient Name (please print) Patient Signature Date