DERMATOLOGY OFFICE
ELLEN TURNER M.D.

4420 West Lovers Lane
Dallas, TX 75209

214-373-7546

7200 N State Highway 161
Suite 230
Irving, TX 75039

Last Name	First Name	MI	
Address	City	State	ZIP
Phone #	Cell #		
SS #	DOB		
Biological Sex: ___Female ___Male ___ Other _____ Gender Identity: ___Female ___Male ___ Genderqueer (Neither male or female) ___ Choose to not disclose Pronouns you use: ___Her/ She ___ He/Him ___ They/ Them Preferred Name: _____			
Email Address		Driver's License #	
Emergency Contact	Relation	Phone #	

HOW DID YOU HEAR ABOUT US?

Referral Name _____ Google _____ Stars and Stripes_____ Insurance website_____

WHO IS YOUR PRIMARY/ REFERRING DOCTOR?

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 PARK CITIES DERMATOLOGY, PA, D/B/A DERMATOLOGY OFFICE, 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 BY ME, 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 DERMATOLOGY OFFICE, 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 DERMATOLOGY OFFICE, ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO RECEIVING SERVICES

Signature: _____ 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.

Insurance Information:

Policy Holder Name _____ Insured DOB _____

Employer _____ Occupation _____

Primary Insurance _____ Secondary _____

Member ID No._____ **Member ID No._____**

Payments:

- **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. Your insurance is a contract between you, your employer, and the insurance company. 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. 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. **Initial** _____

No Shows:

- **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. **Initial** _____
- **SURGERIES:** For medical surgeries that are 30 minutes in length or longer, we ask that you leave your credit card on file. 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. To re-schedule that surgery, you will be required to pay a $100 deposit which would be applied towards your surgery balance. **Initial** _____

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Cosmetic Policy and Procedure:

- **COSMETIC CONSULTATIONS:** Cosmetic consultations with the Medical Assistant and Aesthetician are $75.00. We require a full payment of $75.00 and a credit card on file for anyone scheduling any cosmetic procedures. We also may require prepayment of any cosmetic services or procedures at our discretion. **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. **You will be charged 25% of your procedures total cost if you cancel within 48 hours and 50% if you cancel within in 24 hours of your 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 in advance so that someone else may have your appointment time. In addition to being charged a No-Show fee, we may opt to forfeit your treatment**. We do not guarantee a provider. We only guarantee a service. 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. 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 the office**. 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_____**

CREDIT CARD/ CARE CREDIT POLICY

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. For any amounts greater than $100.00, a representative from our billing department will call you prior to charging your credit card.

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

All cosmetic patients are required to have a credit card on file.

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

I authorize PARK CITIES DERMATOLOGY, PA, D/B/A DERMATOLOGY OFFICE, to charge outstanding balances on my account, after all insurance payments and adjustments have been posted to the credit card listed below:

Name on Card: _____ Credit Card # _____

Exp: _____ Security Code: _____

Signature: _____ Date: _____

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 permit their use for medical publication and teaching purposes, 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 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.

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)

DERMATOLOGY OFFICE
ELLEN TURNER M.D.

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 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 DERMATOLOGY OFFICE, 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 can be 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 Dermatology Office, can make 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_____