7418 N. La Cholla Blvd.
Tucson, AZ 85741
(520) 731-1110 Fax (520) 731-6582

Today's date:	❑ Mrs. ❑ Ms. ❑ Mr. ❑ Miss

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Initial:	Marital Status Single / Married / Divorced / Separated / Widow

Is this your legal name? ❑Yes ❑No	If not, what is your legal name?	E-mail: (provides access to patient portal)	Date of Birth: / /	Age:	Gender: ❑M ❑F

Address:	City:	State:	ZIP :

Home phone:	Cell Phone:	Work Phone:	Social Security Number:

Name of Responsible Party (if not patient):	Address (if different):	Contact Number:	Date of Birth: / /

Any restrictions contacting you?	Is it okay to call you at: ❒ Home ❒ Cell ❒ Work	Can we leave a detailed message on your phone: ❒ Home ❒Cell ❒ Work

Employer:	Occupation:	Preferred Language:

To whom may your medical information be released:	Race:	Ethnicity:

How did you hear about our practice?	Referring Physician Name & Phone:	Primary Care Physician Name & Phone:

Other family members seen here:

IN CASE OF AN EMERGENCY

Name of local friend or relative:	Relationship to patient:
Home phone:	Cell Phone:

The above information is true to the best of my knowledge. I also acknowledge that I have received and understand the HIPAA (Health Insurance Portability and Accountability Act) notice of privacy practices for protected health information from Foothills Dermatology and Facial Plastic Surgery. The release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing. By providing your email, we will grant access to our patient portal.

Patient/Guardian signature	*Date*

Insurance Information

Dr. Olson and Dr. Orlick are contracted with several insurance carriers which require appropriate referrals. Obtaining this referral is your responsibility as the patient. If you are seen without necessary authorization and/or referral, you may be liable for any charges incurred.

Primary Insurance Company:

_____

ID #_____

Group #_____

Policy Holder's Name _____

Policy Holder's SS#_____

Policy Holder's Date of Birth_____

Policy Holder's employer_____

Relationship to Patient _____

Effective Date _____

Secondary Insurance Company:

_____

ID #_____

Group #_____

Policy Holder's Name _____

Policy Holder's SS#_____

Policy Holder's Date of Birth_____

Policy Holder's employer_____

Relationship to Patient _____

Effective Date _____

Assignment of Insurance/Medicare Benefits

I hereby give consent for medical or surgical treatment to the physician to care for myself or I am duly authorized by the patient as his/her guarantor to give consent for such treatment. I understand that co-pays are payable **on the day service is rendered** and any coinsurance/deductibles or other outstanding balance will be billed to me. Failure to pay my co-pay at my appointment, will result in having to reschedule. I authorize Foothills Dermatology and Facial Plastic Surgery to bill my insurance company. I hereby authorize payment directly to the physician of any medical / surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent to release to authorized persons, financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Financial Policy

We are committed to providing you with the highest quality of patient care. A clear understanding of our financial policy is important to our professional relationship. Should you have any questions regarding this financial policy, please don't hesitate to ask for any clarification you may need.

- All patients must complete the Patient Information Forms prior to being seen.
- I understand that my co-pay, coinsurance and deductibles are a contract between me and my insurance company.
- Full payment of co-pays and/or cosmetic services is due at the time of service.
- Coinsurance and deductibles are billed to you and payment is expected on the first bill sent.
- We accept cash, checks and credit cards.
- Any returned check will incur a $25 fee.
- Financing is available through Care Credit. (Apply at www.carecredit.com or fill out an application in our office) Financing options may vary.
- We do have a 24 hour cancellation policy. Failure to cancel your appointment more than 24 hours prior to your appointment time will incur a $25 cancelation fee or a $25 no-show fee if you fail to show up at all.
- Your services may incur additional charges billed by outside vendors including but not limited to pathology services or facility charges.
- I will fully discuss any procedure risks, benefits and alternative treatments with my provider. Risks may include poor cosmetic result, recurrence, bleeding, infection and numbness.

I understand that my contract is between Foothills Dermatology and Facial Plastic Surgery and myself. I agree to pay any balance within two billing cycles. In the event of default of payment, I shall be responsible for all costs of collections, including any legal fees incurred as a result of the collection action. My signature below signifies my understanding of the above policies:

_____ _____

Patient (or Responsible Party) Signature Date