Price Skin Care Clinic
Richard M. Price, MD, PA Jena Smith, NP
212 Draperton Ct., Suite A Ridgeland, MS 39157

DATE _____

PATIENT INFORMATION

Patient Name _____ DOB _____
(Last) (First)

Mailing Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

E-Mail Address _____

Employer _____ Employer Phone _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnic Origin: ☐ African American ☐ Asian ☐ Hawaiian ☐ Native American ☐ White ☐ Other

RESPONSIBLE PARTY INFORMATION

Name _____ DOB _____
(Last) (First) (M)

SS# _____ Phone _____

Mailing Address _____

City _____ State _____ Zip _____

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INSURANCE INFORMATION

Primary _____ Secondary _____

Insurance Company _____ Insurance Company _____

Policy Number _____ Policy Number _____

Group Number _____ Group Number _____

Insured's Name _____ Insured's Name _____

Insured's DOB _____ Insured's DOB _____

Relationship to Insured _____ Relationship to Insured _____

Primary Care Physician _____ Facility _____

How did you hear about our clinic? _____

Emergency Contact _____ Phone _____

The above information is true to the best of my knowledge. I give consent for treatment at Price Skin Care Clinic and authorize my insurance benefits to be paid directly to the provider(s). I understand I am financially responsible for any portion of payment not covered by my insurance company.

Signature _____ Date _____

NOTICE OF PRIVACY POLICIES:

I acknowledge that I was provided with the Notice of Privacy Practices of the medical facility named at the top of this page.

AUTHORIZATION FOR TREATMENT:

I authorize Dr. Richard M. Price, MD, PA, and/or Jena Smith, NP, to provide treatment, which may require diagnostic procedures that require further pathological testing.

PRICE SKIN CARE CLINIC
RICHARD M. PRICE, MD

Price Skin Care Clinic
Richard M. Price, MD, PA Jena Smith, NP
212 Draperton Ct., Suite A Ridgeland, MS 39157

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:

I understand that Price Skin Care Clinic and its' business associates, including the billing company, may use or disclose my health information in communications with third parties that are responsible for payment for my healthcare services. I understand that such third parties might include persons whom are the policy holder of any insurance policy covering me.

I acknowledge that I am entitled to prevent those communications by objecting them, and by my signature below, indicate that **I DO NOT OBJECT** to such communications.

FINANCIAL POLICY:

All copays, co-insurance, and deductible amounts are due at the time of services rendered. Any other amount that your insurance does not cover is due at time of service, also.

Please have your insurance card available on the date of service to ensure the proper insurance is timely filed.

Insurance is filed twice a week. If you have not provided us with your insurance information in a timely manner, the full charged amount will become your responsibility.

For patients who are interested in cosmetic procedures, this is **NOT** a covered service by insurance. 100% of the payment is required on surgery day.

Balances that are past due are required payment in full any time a patient is provided a service in the clinic. Past due balances will be sent to an outside collections company if not paid in a timely manner. The patient will be responsible for all collections fees.

If you fail to cancel or reschedule a missed appointment within 24 hours of the appointment date, a $50 fee will be added to your account.

Signature _____ Date _____

PRICE SKIN CARE CLINIC
RICHARD M. PRICE, MD

Price Skin Care Clinic
Richard M. Price, MD, PA Jena Smith, NP
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MEDICAL RECORDS RELEASE FORM

Patient Name _____ Social Security _____

Address _____ Date of Birth _____

_____ Phone _____

I WOULD LIKE TO REQUEST RECORDS FROM THE BELOW FACILITY (FACILITIES):

Physician/Facility Name _____

Phone _____ Fax _____

Address _____

Physician/Facility Name _____

Phone _____ Fax _____

Address _____

INFORMATION TO BE RELEASED:

I authorize Price Skin Care Clinic to disclose health and/or billing information to the above specified location(s).

It is my understanding that this information is to be used for this reason:

_____

Expiration date for this authorization: _____

I understand that the information described above is subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

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I understand that I may revoke this authorization at any time, except to the extent that action has been taken prior to revocation, by submitting a written request to: Privacy Officer, 212 Draperton Ct. Suite A, Ridgeland, MS 39157.

Patient Signature _____ **Date** _____

If signed by a personal representative, please give relationship and authority to do so:

Signature _____

Relationship to Patient _____ Date _____