Dr. Kuykendall's New Patient Information Sheet

1. First and last name:_____

2. Preferred Name: _____

3. Have you ever met Dr. Kuykendall before? YES NO

If yes, have you ever been a patient of Dr Kuykendall at another clinic within the last 3 years? YES NO

5. Allergies to medications: _____

6. Preferred pharmacy: _____

7. Have you ever had skin cancer (Basal or Squamous Cell or melanoma)? YES NO

8. If over the age of 18, would you like to get in a gown and receive a full skin check? YES NO

9. What are we seeing you for today? _____

10. How did you hear about us? Please list the doctor if referred by another office.
_____

11. If you were not referred by your doctor, would you like us to send records to their office? If so please list their name:
_____

12. Please list any current medications you are on:_____
_____
_____

Patient Information

Name: _____

DOB:_____

Age: _____ Sex: Male Female SSN:_____

Mailing Address: _____
City State Zip

Home Phone:_____

Work Phone:_____

Cell Phone: _____

Email: _____
Responsible Party (if different from patient)

Name: _____

DOB:_____

Mailing Address: _____
City State Zip

Primary Phone:_____

Alternate Phone:_____

Email: _____

Insurance Coverage Form

Primary Insurance:

_____

Name of Policy Holder:

_____

Policy Holder DOB:

_____

Member ID #:

_____

Group #:

_____

Policy type: HMO PPO

Relationship to Holder: Self Spouse Dependent

Secondary Insurance:

_____

Name of Policy Holder:

_____

Policy Holder DOB:

_____

Member ID:

_____

Group #:

_____

Policy type: HMO PPO

Relationship to Holder: Self Spouse Dependent

Financial Policy:

Please read each line and needs to be signed by person over the age of 18

1. Even if we are “in network” with a certain insurance this does not mean that every single plan is in network. It is the patient's responsibility to know your plan.
2. Most insurances today do have a deductible. We do our best to verify your benefits but are not always given correct information and you are responsible for any amount your insurance says on EOB.
3. All co-pays and balances are due in full at check in. All payments on deductibles related to office visits or procedures will be collected at day of service on checkout.
4. Please understand that “covered” services do not mean “paid for by insurance”. If you have a deductible “covered” means you will owe but it will be applied to your deductible.
5. If we are in network with your insurance we legally must file with your insurance. You cannot be “self pay”.
6. If you do not provide proper insurance at every visit then you will be billed for the visit and if it passes timely filing to bill insurance you will be responsible.
7. You will be provided a sheet to fill out insurance information. You must fill out primary and secondary EVEN if you give us your card. This cannot be left blank if you have insurance.
8. If you receive a bill from our office it must be paid within 60 days. If not paid you will be turned to our collection agency. We do charge an additional 50% of the total amount, if goes to collections.
9. If you receive a bill from our pathology lab you must contact them. They have a completely separate department to pay their doctors and staff.
10. If your insurance requires a referral it is up to you as the patient to have this in place or you are responsible for the visit.

No shows/cancellations

Due to the high rate of last minute cancellations and no shows we have implemented the following policy.

1. A no show is anyone who no calls/no shows for their appointment. Your credit card will be charged $100. All cancellations not made within 24 business hours, your credit card will be charged $50 **Initials_____**
2. We only allow 3 re-schedules a year that are not made 1 week in advance. It has become disruptive to patients who need in when appointment slots are filled.

Social media:

1. We ask that you be considerate of us on social media and please do not send Dr Kuykendall texts or Facebook messages.

Person responsible for payment Name (Print):

_____

Name (Signature):

_____Date_____

HIPAA Release Form
Kuykendall Dermatology

I _____ authorize the release of information of
(Print Patient/ Guardian Name)

_____, including the diagnosis, records, examination
(Patient Name) and treatment rendered to above patient, ledger and billing, and claims information.

This information may be release to (please write their name):
• Spouse:_____
• Child(ren):_____
• Other:_____
• Information is not to be release to anyone (initial here):_____

In further consideration for this, Kuykendall Dermatology agrees to the same stipulations. This release of information will remain in effect until terminated by me in writing.

Message and communication from our office:

If we are unable to speak directly to you pertaining to your care, please check one of the following preferences:
•__ You may leave a detailed message.
•__ Please leave a message asking me to return your call.
• Other: _____

The best phone number to reach me at is: _____

Signature: _____ Date _____/_____/_____

HIPAA Acknowledgement Form

Patient First Name: _____

Patient Last Name _____

Relationship to the patient _____

Name if not the patient _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: -Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly -Obtain payment from designated third-party payers. Conduct normal health care operations such as quality assessments or evaluations, and physician certifications. I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link HIPAA Notice of Privacy Practices or in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Kuykendall Dermatology has the right to change its Notice of Privacy Practices from time to time and that I may contact Kuykendall Dermatology at any time to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that Kuykendall Dermatology restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Kuykendall Dermatology is not required to agree to my requested restrictions, but if Kuykendall Dermatology does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Kuykendall Dermatology has taken action relying on this consent.

By checking the box I acknowledge that
• I received and read this organization Notice of Privacy Practices:

Signature:_____

Date:_____

Kuykendall Dermatology, PC
1218 E 9th Street
Edmond, OK 73034
Phone: (405) 301-8010

CREDIT/DEBIT CARD ON FILE:

A copy of your credit card is now required to be on file for billing of your deductible/co-insurance and co-payment, as well as any non-covered services that are Provided.

Once your credit card information is entered, it is encrypted on CardPointe and cannot be viewed by anyone in our organization. CardPointe is registered with Visa, Mastercard, and Discover and is independently certified as a PCI-DSS Level One Service Provider.

By signing below, you acknowledge that you understand and agree to the terms of this consent.

Patient Signature:

_____ _____

Patient or Legal Guardian **Date**

Printed Name:

_____

Patient or Legal Guardian