



27700 Highway 290 Suite 490
Cypress, Texas 77433
281.895.3376
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www.cypressdermatology.com

PLEASE COMPLETE THE ENTIRE FORM. IF NOT APPLICABLE, AFFIX N/A.

First name: _____
Address: _____
Email: _____
Preferred language: * _____
SSN: _____
Date of birth: _____
Primary phone # _____ Type: _____
Secondary phone # _____ Type: _____

Last name: _____
City _____ State: _____ Zip code _____
Employment status: ☐ Employed ☐ Retired ☐ Other _____
Employer: _____ Office # _____
Student status: ☐ Full ☐ Part School name: _____
Emergency contact: _____ Phone #: _____
Emergency contact relationship: _____
Primary provider: _____

*Recent government reforms require this information.
This applies to all patients.

Referring physician: _____

Referral source: ☐ Insurance Directory ☐ Provider ☐ Event
☐ Google ☐ Other: _____

Preferred contact method: ☐ Text ☐ Phone

Gender: ☐ Male ☐ Female

Race: * ☐ White ☐ Black/ African American
☐ Hispanic ☐ Native Hawaiian ☐ Asian
☐ Other ☐ American Indian

Marital Status: ☐ Married ☐ Single: _____

Ethnicity: * ☐ Hispanic/ Latino
☐ Not Hispanic/ Latino ☐ DECLINE

INSURANCE INFORMATION

Primary insurance: _____
Name Policy holder: _____
Date of Birth: _____ Relationship: _____
Member #: _____
Group #: _____
Group name: _____
Effective: _____

Secondary insurance: _____
Name Policy holder: _____
Date of Birth: _____ Relationship: _____
Member #: _____
Group #: _____
Group name: _____
Effective: _____

PLEASE INDICATE INITIAL:

- ☐ The information I provided above is truthful and accurate, and any discrepancy may result in further clarification. (Required)
- ☐ I authorize **CYPRESS DERMATOLOGY**, to furnish information concerning my condition and treatment to my insurance carrier(s). If you do not want us to submit your visit info to your insurance, the patient/financially responsible party accepts the full financial responsibility for cost incurred during the visit(s). (Required)
- ☐ I authorize payment of medical benefits to **CYPRESS DERMATOLOGY** (Required)
- ☐ I understand that I am responsible for any part of the charges that are not covered by my insurance. (Required)
- ☐ I understand that I will be charged \$50 fee for cancellations made less than 24 hours before scheduled appointment. (Required)
- ☐ I give my permission to **CYPRESS DERMATOLOGY** to email me promotional offers on products and services. (Optional)

SIGNATURE

(Patient or Parent/Guardian if patient is a minor)

TODAY'S DATE

Please read carefully and initial each paragraph.

PHOTOGRAPHY

☐

The undersigned patient or legal guardian hereby authorizes Cypress Dermatology to take, use, and copy a photo of patient, including but not limited to the face. The photo(s) will **only** be used for purposes of identification and documentation of the progress of patient's condition. I understand that no photographic image of the patient will be disseminated outside of Cypress Dermatology for commercial purposes without my further consent.

USE OF PROTECTED HEALTH INFORMATION

☐

I authorize Cypress Dermatology to use and disclose Protected Health Information (PHI) of the patient for the purposes of carrying out treatment, payment, and healthcare operations (TPO). The complete description of such uses and disclosures can be found in our Notice of Privacy Practices.

☐

I received a copy of the Notice of Privacy Practices prior to signing this consent.

☐

With this consent, Cypress Dermatology may call and/or send mail to me or to person listed on the Patient Disclosure form in order to assist them in carrying out TPO. This includes but is not limited to appointment reminders, insurance items, laboratory results, financial statements and any other information pertaining to my clinical care.

☐

I understand that I may revoke my consent in writing, except for the information that the practice has already made disclosures of before the consent was revoked. Cypress Dermatology reserves the right to decline treatment to me/the patient once the consent has been revoked.

Patient's Name

Date

Patient/ Legal Guardian Signature

Printed Name of Guardian

Commercial and non-commercial insurance

Cypress Dermatology will bill your insurance(s) for services rendered during your visits provided that your insurance carrier will make payments directly to Cypress Dermatology

Medicare

Cypress Dermatology will accept assignment from Medicare. The patient is responsible for the 20% co-payment. If you have a Medicare supplement, we will file a claim with them provided they will make payments directly to Cypress Dermatology.

Referrals

If your insurance requires a referral from your primary care physician (PCP), please make sure that your PCP has been notified of this appointment. A copy of the referral must be provided to you and Juno Dermatology, LLC prior to your appointment. Cypress Dermatology is not responsible for procuring referrals.

Claim Submission

In the event the patient has insurance coverage but cannot provide documentation, charges will be entered as self-pay. Upon the submission of the insurance card, we will submit a health insurance claim form. Secondary insurance will be billed upon the submission of proof of secondary insurance. Cypress Dermatology has the right to deny use of insurance card if patient's name on the card does not match that listed on a government issued identification card.

Insurance Release

I authorize Cypress Dermatology to release required information to my insurance company, hospitals and other medical providers regarding services provided, including medical, laboratory studies, HIV testing, and other medical data related to my care.

Financial agreement

I understand that my insurance contract is between me and my insurance company. In the event the insurance does not pay for billed services, the balance will be the patient's/ legal guardian's responsibility. Cypress Dermatology, LLC will forward the account to collections if the patient fails to settle the account balance on the due date or fails to make suitable financial arrangements. The patient/legal guardian will be responsible for collection fees that may include but not limited to court fees, attorney fees, and any other fees incurred during the collection process. Moreover, I consent to Cypress Dermatology making appropriate inquiry on my credit history in conformity with legitimate business needs and applicable laws, rules, and regulations.

Forms and Release of Records

The completion of administrative forms about your care and duplication of records is not a part of your routine medical services with us. We are happy to assist you in any way possible, but we reserve the right to charge appropriate fees for these extra services, based upon time and effort involved. If you request copies, we charge you up to **\$15.00** to locate and copy your records, plus postage if you want them mailed to you. Requests must be made in writing by completing our record release form. There is no cost to provide records to facilities or physicians that we refer you to see.

Patient's Name

Date

Patient / Legal Guardian Signature

Printed name of Guardian

Patient's name: _____

Date of birth: _____



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