Rodney S. W. Basler, MD
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South Lincoln Dermatology Clinic

Patient Information

Patient Name: ______________________________ Preferred Name: __________
Last Name First Middle Initial

Social Security Number: ______________ Date of Birth: ________ Sex: Female / Male

Race: __________ Preferred Language: ______________ Marital Status: S M D W

Home Address: ____________________ City: __________ State: ___ Zip: _____

Cell Phone: ___________________ Home Phone: ________________________

Employer: ________________________ Phone: ______________________

Email Address: _____________________

Emergency Contact: __________________ Phone: ______________________

Spouse: __________________________ Phone: ______________________

Care Taker: ________________________ Phone: ______________________

Medical Information Release

(Privacy Policies are located at the reception desk)

Please check phone number where we may leave a detailed message:

□ Cell Phone □ Home Phone □ Work Phone

Please check phone number where we may leave a message for you to return our call:

□ Cell Phone □ Home Phone □ Work Phone

Check your preferred contact method: □ Cell Phone □ Home Phone □ Work Phone

People allowed access to my medical records (Family/Friend):

Name: _________________ Relationship: ___________ Phone: __________
Name: _________________ Relationship: ___________ Phone: __________
Name: _________________ Relationship: ___________ Phone: __________

______________________________________ ___________________

Signature of Patient or Guardian **Date**

INSURANCE INFORMATION

Does your insurance require a referral? ☐ Yes ☐ No

If yes, please list referring physician information:

Physician's Full Name: ______________________________ Phone: ____________________

☐ Self-Pay

PRIMARY INSURANCE

Insurance Name/Phone: ____

Policy Number: ______________________ Group Number: ____________________

Patient's Relationship to Policyholder: ______________________________

Policyholder's Name: ____

Policyholder's Date of Birth: ______________ Policyholder's SS #____________________

SECONDARY INSURANCE

Insurance Name/Phone: ____

Policy Number: ______________________ Group Number: ____________________

Patient's Relationship to Policyholder: ______________________________

Policyholder's Name: ____

Policyholder's Date of Birth: ______________ Policyholder's SS #____________________

PATIENT RESPONSIBLE IF OTHER THAN PATIENT

Name: ______________________________ Phone: ____________________

Date of Birth: ______________________ Social Security Number: ________________

Relationship to Patient: ____

Address: ______________________ City/State: ________________ Zip: ________

Employer: ______________________________

____ ____________________

Signature of Responsible Party **Date**

SOUTH LINCOLN DERMATOLOGY POLICIES

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical insurance coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. Know that your copay is due at the time of service. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. It is in your best interest to understand your insurance plan and ultimately you are responsible for knowing and understanding your coverage. Any balance left after insurance benefits have been paid are the responsibility of the patient.

Consent for Medical Treatment and Minor Procedures:
I understand that:

- During the course of my visit, my doctor may recommend that a procedure be performed. Such procedures include but are not limited to: liquid nitrogen destruction (Freezing), biopsies, shave removals, excisions, incision and drainage, scissor snip excision, curettage (scraping), electrodessication (use of cautery/heat), and steroid injections.
- The risks, benefits, and alternatives to these procedures will be explained at the time of my visit, prior to my doctor performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Any and all procedures are optional. I may choose to decline a procedure for any reason
- **Photographs may be taken of me and kept in my medical file and will not be used in any other manner without my express written consent.**
- There is no guarantee of results as medicine is not an exact science.
- Some procedures may need to be performed more than once to achieve optimum results.
- Procedures may incur additional charges, and I am responsible for payment.
- If a procedure is deemed cosmetic, and therefore not covered by my insurance, I will be responsible for payment.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.
- If I have a biopsy done, the specimen will be sent for pathologic evaluation and I will be billed for any amount not covered by my insurance.

Assignment and Release
I authorize payments to be made directly to South Lincoln Dermatology by my insurance company. I authorize the release of any medical care information requested by my insurance company. I accept financial responsibility for all services not covered by my insurance. I have read “Consent for Medical Treatment and Minor Procedures” and I consent to routine minor procedures and medical treatment.

Acknowledgment of Receipt of Notice of Privacy Practices
By signing below, I acknowledge that I have read the South Lincoln Dermatology Assignment and Release statement, as well as the Notice of Privacy Practices. These statements describe how my health information may be used or disclosed in order to receive benefits. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the clinic location where I receive health care services.

____ _______________________________________

Signature of Patient or Responsible Party **Date**

If you are not the patient, please fill out the following information:

____ _______________________________________

Name **Relationship to Patient**