



4615 Parliament Drive #204, Alexandria, LA 71303
216 University Pkwy, Natchitoches, LA 71457
P: (318) 321-5245 | F: (318) 542-4322

Patient Registration Form

Patient Information:

Full Legal Name: _____ SSN: _____

DOB: _____ Email: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _ (_____) _____ - _____ Cell Phone: _ (_____) _____ - _____

Other Information:

Primary Care Physician: _____

Address/Location: _____

Preferred Pharmacy:

Pharmacy Name: _____ Location: _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ SSN: _____

Relationship to patient: _____ DOB: _____

Address: _____ Phone: _____

Emergency Contact: Name: _____

Address: _____ Phone: _____

Relationship: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Dean Derm, I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Patient/Guarantor Signature: * _____ Date: _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Patient Medical History

Patient Name : _____ Date: _____

Please list any medical conditions and surgeries that apply to you:

Medical conditions:

Surgeries:

Allergies:

Medications:

Dosage:

Frequency:

Do you have a history of skin cancer? Yes No **65 and older only**
 If so, what type? Do you have a health care proxy? Yes No
 If yes: Name: _____
 Are you pregnant or nursing? Yes No Phone: _____

Do you use tobacco/smokeless tobacco? Yes No
 Frequency?
 Circle One:
 Cigarettes, Vape, Smokeless, Other

Do you drink alcohol? Yes No
 Frequency?
 Have you ever used a tanning bed? Yes No

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Identification

Printed Name: _____

Address: _____

DOB: _____ Telephone: _____

Authority to Release Protected Health Information

I hereby authorize: _____ (“Provider”) to release the information identified in this authorization form from the medical records of Provider and provide such information to **DEAN DERM:**

Dr. Rachel Dean

Amy Suter, PA

Cyndie Plaisance, NP

Mail or fax to : Dean Derm Phone: 318.321.5245

 4615 Parliament Dr. Suite 204 Fax: 318.542.4322

 Alexandria, LA 71303

The following information is to be released

- Specific medical records only: _____

- A Certified Copy of the entire medical records file, including but not limited to: office notes, correspondence, existing narrative reports, x-ray films and reports, CT Scan films and reports, diagnostic films and reports, etc., hospital records, lab results, HIV test results, patient intake forms, initial application and information sheets, consultation reports, physical therapist reports, billing records, appointment records, progress notes, handwritten notes, nurses’ notes, records of prescriptions, patient orders, pathology slides, insurance claim forms, or any and ALL records compiled by you or in your possession pertinent to the treatment of me.

This release authorizes the release of tangible medical information and verbal communication by the health care provider to the requesting party.

Purpose of the Requested Disclosure of Protected Health Information: I am authorizing the release of my Protected Health Information for the following purposes: at the request of the individual.

Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to Provider.

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure: I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can inspect or copy the protected health information to be used or disclosed.

A photostatic copy of this Medical Release Authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Description of relationship if not patient: _____ Date: _____

Financial Disclosure

You can expect to receive the following bills as a result of your visit:

- Physician Fee: Fee to be paid to the physician for performing the service. This bill will be from Dean Derm.
- Lab Fee: If a lab test is ordered, a second bill will come from an outside lab.
- Pathology Fee: When a pathology test is ordered, a second bill will come from an outside pathology lab.

Insurance: Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid your bill. The EOB will also explain any amount for which you may be responsible. Some insurance plans require you to pay different out of pocket amounts based on where the service is performed. Deductibles, coinsurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. Dean Derm will submit primary, secondary, and tertiary claims for our contracted payers on your behalf. If the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit, the patient or guarantor is responsible for the balance.

Co-payments: Dean Derm collects co-payments at the time of service. Additional payment may be required based on your insurance plan. In the event your account has a credit, a refund will be issued in a timely manner.

Refunds: All refunds will be processed within 3-5 weeks after the overpayment is discovered on the account or at the time a refund is requested. Patients who have insurance but made a partial payment or payment in full will not be refunded until payment is received in full from their insurance company. Refunds for prepaid events will be processed within 5-7 business days. For refunded payments a check will be issued to the patient.

Initial below:

_____ If we are unable to verify you have active coverage on the date of your appointment you will be required to pay for the visit in full at the time of service. If your insurance later pays for your visit, we will issue you a refund.

_____ A \$25 fee will be incurred for returned checks.

_____ In the event we need to contact you regarding a billing matter, we may call you on your cell phone if you have listed this number as your primary or alternative contact number.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:

Call the office at 318-321-5245 and ask to speak to the billing department.

No-Show or Untimely Cancellation of Appointments

_____If you are unable to keep your appointment, please cancel at least 48 hours in advance to allow time to schedule other patients who are waiting for appointments. If they are not cancelled prior to 48 hours or no-show appointments will result in a \$25 fee for a routine medical visit and a \$50 fee for surgery time slots.

_____ For laser and aesthetic procedures, appointments must be canceled at least 48 hours in advance to avoid a \$50 no show fee. If you no show three appointments, you will no longer be able to schedule an appointment. It is up to the discretion of the provider if they would like to continue to see you.

Patients Reassignment and release statement

By signing below, I indicate my understanding of Dean billing practices and that I may receive multiple bills related to my office visit as explained above. I authorize payment of medical benefits to PDA and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any copayments, deductibles, co-insurance and non-covered services as outlined by my health plan. This agreement applies to all visits that take place one year from the date this is signed, and any bills resulting from those visits.

Patient/Guarantor Signature*

Date

*If patient is a minor (under the age of 18), form must be signed by a parent or a legal guardian.

Notice of Privacy Practices Acknowledgment

Acknowledgement of Receipt

I, _____, hereby acknowledge that Dean Derm has given me the opportunity to read a detailed notice of their Privacy Practices.

Patient/Guarantor Signature: _____ Date: _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

*If not signed, please provide a reason why the acknowledgement was not obtained.

Witness: _____ Date: _____

(Staff Signature)

Consent to release information

In the event I cannot be reached, I, _____, give permission for a representative from Dean Derm, to speak with family member(s) or companion(s) listed below regarding care or test results.

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Is it OK to leave results or information on your voicemail? **YES** **NO**

Patient/Guardian Signature: _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Consent to correspond electronically

While Dean Derm takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication. I acknowledge that if I use electronic mail to initiate contact with a Dean Derm physician regarding my medical care, that his/her representative has my permission to correspond via that email address. I give permission for a Dean Derm physician or clinic staff member to email me at regarding my medical care.

- I consent to having communications sent to you via email. (Examples: appointment reminders, administrative updates, etc.)

Patient Signature: _____ Date: _____