RADIANT
DERMATOLOGY & AESTHETICS

Liet N. Le, MD, FAAD
P : 281-973-4159 F : 281-973-2359

Patient Information Form

Today's Date: ____/____/____

General Information

Patient Name: _____
Last First Middle Initial

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ Driver's License #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino ☐ Other ☐ Unknown ☐ Declined

Occupation: _____ Employer: _____

Primary Care Physician: _____

How did you find our office? ☐ Google ☐ Yelp ☐ Facebook ☐ Insurance ☐ Advertisement ☐ Other: _____

If referred by family/friend, please leave their name: _____

Contact Information

Mailing Address: _____
Street City State Zip

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Email Address: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

Emergency Contact Information

Name: _____ Relationship:_____ Number:_____

Insurance Coverage

PRIMARY HOLDER INFORMATION

Insurance Co. Name: _____

Policy Type: ☐HMO ☐PPO Policy #:_____ Group Name or #: _____

Name Policy Holder (Insured): _____ Date of Birth: ____/___/____

Check relationship: ☐ Mother ☐ Father ☐ Spouse ☐ Other: _____

SECONDARY INSURANCE

Insurance Co. Name: _____

Policy Type: ☐HMO ☐PPO Policy #:_____ Group Name or #: _____

Name Policy Holder (Insured): _____ Date of Birth: ____/___/____

Check relationship: ☐ Mother ☐ Father ☐ Spouse ☐ Other: _____

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Financial Policy

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances, MUST BE PAID AT TIME OF SERVICES including services that are not covered under the patient's benefit plan

Office Policies

Welcome and thank you for choosing **Radiant Dermatology & Aesthetics** for your medical care. WE are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

_____ **Insurance**: The patient is responsible for knowing their insurance benefits including their deductible and out-of-pocket expense. Copay, deductibles, and patient's financial portion including any balance WILL BE COLLECTED AT THE TIME OF SERVICE. You may be asked to reschedule your appoint for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

_____ **Cancellations:** Please call our office 24 hours in advance if you are unable to keep a scheduled appointment. If you DO NOT CANCEL WITHIN 24 HOURS, you may be charged a **no-show fee of $25.** If you fail to cancel in advance and subsequently no-show for your appointment time you will be given a one-time warning. If you no-show twice in a row, the physician has the right to refuse service. You may try to schedule with our advanced practice providers when they are available. Please know we value all of our patients and simply want to ensure timely treatment for all parties involved.

_____ Surgery Cancellations: If you need to cancel/reschedule a surgery please contact the office 48 hours prior to procedure date. This is imperative as many of our patients need to be scheduled and require adequate time to be informed. Please **REFER** to our **cancellation/no-show** policy above. Non-compliance could result in a **$50 fee.**

_____ **Late Arrivals**: We do our best to have a short patient wait time but when a patient arrives late, it makes this goal more difficult. If you arrive **15 minutes late** you may be **asked to reschedule** your appointment.

_____ **Referrals:** Patients with an **HMO policy** need referrals to see any specialist. You may be required to go back to your primary care physician to obtain a referral for a specialist that we recommend. This is an HMO guideline that we have no control of.

_____ **Patient Balances**: Please be prepared to pay the current visits, as well as, any past balances on your account. Copay, deductibles, out-of-pocket expenses and non-covered services **WILL BE REQUIRED AT TIME OF SERVICE.** For your convenience we accept the following forms of payment: cash, check, and/or credit cards.

_____ **Dishonored Checks:** A $30 return check fee will be assessed on all dishonored checks. If you have 2 dishonored checks on file, check payment WILL NO LONGER be a payment option for you but we will gladly accept cash or credit card payments on your future visits.

____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure you make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records. Otherwise, your account WILL BE TURNED OVER TO COLLECTIONS when it is returned as a bad address. Wen your account is already in collections, you **may not** be seen until the account is paid in full at the collection agency.

_____ **Prescriptions:** It is the PATIENT'S RESPONSIBILITY to call the pharmacy 5 days prior to running out of medication. Refills may take 2-4 business days to be refilled.

I have read, understand, and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize the release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name (Print): _____ DOB: _____

Patient Signature: _____ Today's Date: _____