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 who is financially responsible for this visit

1. We are in network with most insurances. Just because we are “in network” with a certain insurance does not mean that every single plan is in network. It is impossible for our staff to know every plan and it is ultimately up to you as a patient to understand physicians in network.
2. Most insurances today do have a deductible. Sometimes this applies to both the office visit and any procedures. Please voice to us if you would like an estimate on costs if you have a deductible. We do our best to verify your benefits but this is very complicated in the way insurance companies explain on websites so sometimes we get it wrong (not to our fault). If you receive a bill and was told something different in our office please understand our staff does their best with the information that is available to us.
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. As a dermatology office we frequently do things that are considered cosmetic. The doctor will tell you 100% of the time if it is considered cosmetic and the price. Please do not call us after the fact asking to file with insurance. It is confusing but sometimes the code is “covered” (which confuses patients) but the law clearly states that if a physician files a benign lesion with insurance then that is subject to federal prosecution. So please understand that when you are told that something cannot be turned into insurance we promise you are given correct information. Sometimes we do consider things as not cosmetic and will bill your insurance. This does not guarantee that your insurance agrees with us and may consider services “not medically necessary”. Even though we do not agree with the insurance you will be responsible for the charge if this happens. We do our best to fight this but will work with you on the cost if this happens.
7. 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.
8. Please call us ASAP if for some reason your insurance was billed wrong so we can correct it.
9. 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. We refer to this frequently if there are any discrepancies.
10. 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. To make up the fees of the collections agency we have had to turn in 2X the amount owed so please pay as soon as you can. If the bill is over $300 and you are having financial hardship please reach out to set up a payment plan.
11. 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. We have no way of knowing lab benefits related to your insurance.

12. If your insurance requires a referral it is up to you as the patient to understand this process. Most insurances do not require a referral but it is up to you to have it sent to us to bill or you will be responsible for the bill.

No shows/cancellations

Due to the high rate of last minute cancellations and no shows we have implemented the following policy A no show is anyone who no calls/no shows for ther appointment. Your credit card will be charged $100.

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.

2. Late people. We are very forgiving of lateness in certain circumstances. However we must see people who were here on time and you will have to wait until we can get you back on schedule. Please do not ask the front desk staff when that will be because they are not in the back office but we do our best to accommodate but makes it very hard when more than one person is late.

If you are a new patient you are asked to be here 20 minutes early so are considered late if you show up at your appointment time or only 5 minutes before.

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. She is overwhelmed with constant medical questions and pictures that cannot be answered appropriately this way. If you are having trouble contacting the office we do want to know about it but we ask that you please do not send medical information via text or Facebook messenger.

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