SKIN RENEW
DERMATOLOGY & LASER CLINIC

8119 Isabella Lane, Suite 100 Brentwood, TN 37027 • P: 615.376.7700 • F:615.376.7775 • www.skinrenewclinic.com

PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

TELEPHONE: Home (_____)_____Cell (_____)_____Work (_____) _____

EMAIL ADDRESS _____

SOCIAL SECURITY # _____ DATE OF BIRTH_____ AGE _____

PATIENT PLACE OF EMPLOYMENT _____

Retired _____ Full Time Student _____ Part Time Student _____

Referring Physician _____

Who referred you to our office? _____

In case of emergency contact _____ Telephone # (_____) _____

If patient is a minor or has a guardian, please enter responsible party information. Note: We do not bill absent parents.

NAME_____ RELATIONSHIP _____

ADDRESS _____

SOCIAL SECURITY # _____ DATE OF BIRTH_____ AGE _____

PLACE OF EMPLOYMENT _____

Attach copy of insurance cards PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

____ **I hereby authorize** Skin Renew Dermatology & Laser Clinic to furnish my insurance company any/all information which said insurance company (s) may request.

____ **I hereby assign to** Skin Renew Dermatology & Laser Clinic all money to which I am entitled for medical and/or surgical expenses relative to the service rendered.

____ **I understand that I am financially responsible** to Skin Renew Dermatology & Laser Clinic for charges not covered by this assignment including medical and cosmetic services.

____ **I agree to pay any balance after insurance payment within 20 days.**

____ **I agree to pay all collection costs, court costs and reasonable attorney fees if I fail to promptly pay this account when due and unpaid balance is turned to collection service.**

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST.

Patient Signature_____ Date _____

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Cancellation/Missed Appointment Policy

We will make every effort to accommodate your scheduling needs. We ask that you help us by keeping your scheduled appointment. If you are unable to keep your appointment, please notify us 24 hours in advance. If you are unable to provide 24 hours notice, you may be charged a $50 cancellation fee.

If you arrive more than 10 minutes past your scheduled appointment, we may have to reschedule your visit. This ensures timely treatment for the subsequent patients on the schedule.

Any appointment fees must be satisfied prior to your visit/treatment. If you should miss three (3) appointments, we reserve the right to cancel any standing appointments and you will forego any prepaid service balance.

Thank you for your assistance and compliance with our appointment policy. By signing below, you state that you have read and understood the above policy.

Patient or Legal Guardian Signature _____

Please print your name:_____ Date _____

Overview of HIPAA Privacy Practices Notice

Federal law requires Skin Renew Dermatology & Laser Clinic and its related health care providers to maintain the privacy of individually identifiable health information and to provide you with notice of their legal duties and privacy practices with respect to such information. Skin Renew Dermatology & Laser Clinic and its related health care providers must abide by the terms and conditions of this Privacy Notice.

The health care providers affiliated with Skin Renew Dermatology & Laser Clinic are required to seek your written acknowledgement that you have received this Notice. By furnishing written acknowledgement of receipt, you do NOT indicate your agreement or consent to the uses and disclosures of information described in this Notice. The acknowledgement indicates only that you have received this Notice. You may decline to furnish written acknowledgement of receipt. In this event, your refusal will be documented.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU WILL BE PROTECTED, HOW IT MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Patient or Legal Guardian Signature _____

Please print your name:_____ Date _____