Mercer Island
DERMATOLOGY
Allison Hughes MD, PhD

Full Name: _____**DOB**: _____Preferred Name**:** _____
First *MI* *Last*

Sex: M / F /Other Marital Status: ☐ Single ☐ Married ☐ Other: _____Social Security Number: _____

Preferred Language: ☐ Decline to specify ☐ English ☐ Spanish ☐ Other: _____

Ethnic Group: ☐ Decline to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Decline to specify ☐ White ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American ☐ Other

Emergency Contact/Full Name: _____Phone: _____

Preferred method of contact: ☐ Phone ☐ Text ☐ Email ☐ Decline to receive reminders

Home Phone: _____Work Phone: _____Mobile Phone: _____

Preferred Phone: ☐ Home ☐ Work ☐ Mobile **Is it okay to leave detailed messages? ☐ YES ☐ NO**

Email Address: _____

Mailing Address: _____
Street *City* *State* *Zip*

Employer: _____ Occupation: _____

Preferred Pharmacy Name: _____
Address or street

Phone#: _____City or Zip code: _____

Primary Care Doctor: _____
Full name *Location*

Referring Doctor (if applicable): _____
Full name *Location*

I was referred here by: ☐ Facebook ☐ Instagram ☐ Twitter ☐ Yelp ☐ Other: _____

Release of Information:

I give permission to the following person(s) to speak with anyone from Mercer Island Dermatology Office, about my health condition, billing information, and any other relevant information.

Name: _____ Phone: _____Relation to Patient: _____

(Any authorizations given will automatically expire after 3 years from date of signature)

Insurance Information:

Policy Holder (*if different from patient*): Patient relationship to subscriber: (Circle one): Spouse Child Other

Primary Insurance Policy Holder Name: _____ DOB: _____

Secondary Insurance Policy Holder Name: _____ DOB: _____

Guarantor Information: *Is someone else responsible for your bill? Please enter their information below:*

Name:_____Relationship:_____

Address:_____ Phone#:_____

Acknowledgment and Authorizations:

- *I authorize my insurance company to pay benefits on my behalf directly to Mercer Island Dermatology PLLC, Dr. Allison L. Hughes, MD, PhD. I authorize Mercer Island Dermatology PLLC, Dr. Allison L. Hughes, MD, PhD to provide to my insurance company, any information necessary to process claims for services rendered to me.*
- *I understand and have received a copy of the Notice of Privacy Practices for Mercer Island Dermatology, PLLC, Allison Hughes MD, PhD.*
- *I understand that I will be charged a fee of $75.00 for a missed appointment ($150.00 if surgical visit) unless I notify the office 48 hours prior to my scheduled appointment. When scheduling a cosmetic procedure in advance, I will be required to make a credit card or cash payment for 100% of the fee in order to hold my appointment.*

Patient or Responsible Party Signature: _____Date_____/_____/_____

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OFFICE FINANCIAL POLICY

Dear Patient,

We would like to share the following policies with you so that you understand your responsibility regarding the charge for the services rendered to you by this office.

1) If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

a. The annual deductibles
b. Copayments
c. Charges for non-covered or cosmetic services

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

2) We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

a. The annual deductibles
b. Copayments
c. Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received for your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

3) For non-Medicare patients who have insurance coverage with any insurance carrier with which we do not have a contractual relationship, please note the following:

a. We will file both your primary and secondary insurance. If we do not receive payment for your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

c. If you only have primary insurance (e.g., no secondary/supplemental coverage) any amount not paid by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage for benefits. The entire balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement.

4) For patients who do not have medical insurance you will be paying for services yourself as a private pay patient. If you have insurance and we are contracted with that insurance company, we are bound by our contract with the insurer to bill them directly. By signing below, you are acknowledging that you have no insurance, including Medicare, and that you are accepting full responsibility for physician, laboratory, and diagnostic services provided to you on your behalf.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

I understand that I am responsible for payment of my account at the time of services for non-covered services, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

Signature Date

Patients Name