ADVANCED Dermasurgery Associates

Dr. Saira Momin
Dr. William Posten
Sarah Snitker, PA-C
American College of Mohs Surgery
Fellowship trained * Board certified

PATIENT INFORMATION SHEET

Email Addres: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Please Circle: DR. MR. MRS. MISS MS. MALE FEMALE

Race: American Indian Asian Pacific Islander Black or African American White Hispanic Other Race

Patient's Full Name:_____
Last First Middle

Mailing Address:_____
Street City State Zip

Marital Status: Married Divorced Single Widowed

Social Security#_____-_____-_____ Age_____ Date of Birth_____

Occupation of Patient:_____

Employer:_____ Employer's Phone#_____

Employer's Address:_____

Pharmacy Name:_____ Phone#/Address:_____

Were you referred by another physician? If yes, complete below:
Doctor's first and last name_____

Address and phone number_____

Who is your Primary Care Physician? Name, address, phone number _____

PRIMARY INSURANCE INFORMATION
Name of Insurance Policy Holder if other than yourself. (If self, please write "self")

_____
Last First Middle

Social Security#_____-_____-_____ Date of Birth_____

Relationship to Patient:_____Address:_____

Employer Name and Address:_____

Primary Insurance Company:_____

ID#:_____ Group#:_____

Does patient have other insurance? Yes_____ No_____ (If Yes, fill out secondary insurance)

SECONDARY INSURANCE INFORMATION

_____
Last First Middle

Social Security#_____-_____-_____ Date of Birth_____

Relationship to Patient:_____Address:_____

Employer Name and Address:_____

Secondary Insurance Company:_____

ID#:_____ Group#:_____

We require an emergency contact person for all patients. By signing this form you are giving Advanced Dermasurgery Associates permission to contact your emergency contact listed below in case of an emergency.
Name of person to contact in case of an emergency: (must be 18 years of age)

_____

Last First Middle

Relationship to patient:_____

Occupation:_____ Employer:_____

Employer's Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

OUR FEE POLICY: To control costs, we ask our patients to pay for their office visit, copayment, deductible, coinsurance and any non-covered services at the time services are rendered.

I UNDERSTAND that I am responsible for copayment, deductible, coinsurance and/or any non-covered services. I will notify you of any changes in my health status or health insurance. I further understand that if a specimen is sent to an outside lab for processing, you will get a separate bill from the lab. We will send your insurance information to the lab for them to bill your insurance. The lab charges for specimens sent to an outside lab are separate from Advanced Dermasurgery Associates.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: Advanced Dermasurgery Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all copayments, coinsurance and any non-covered services. I hereby authorize said assignee to release all information necessary to secure the payment.

NOTICE TO PATIENTS: Per Medicare regulations, we are required to furnish you with the following information:
Dr. Posten has privileges at the following hospitals: VA, Parkland, Baylor Irving, Medical City Hospital and Presbyterian Hospital of Dallas.

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section102.006 of Texas Occupations Code.

Facility with affiliation and remunerations: ADG Houston Pathology, PLLC.

_____ _____

Signature Date

For Minor Patients if applicable:
I give permission for you to see and treat _____ my minor son/daughter in your office.

_____ _____

Parent or Guardian Signature Date