

PATIENT INFORMATION

Last Name	First Name					
Home Address			City	Sta	te	Zip
Marital Status	SSN	Employer		Occupation		
Primary Care Doctor		Prima	ary Care Phone Number			
Pharmacy	Pharm	nacy Phone Number	Pharmacy /	Address (or C	City and cro	oss streets)
ONTACT INFORM	<u>IATION</u>					
ome Phone:			Leave voicemail?	YES	6	NO
ell Phone:			_ Leave voicemail?	YES	6	NO
			Send text messages?	? YES	6	NO
mail Address:						
	ISION MAKER one that can make med	lical decisions on yo	our behalf if you are ur	nable to?	YES	NO
o you have someo IF YES, name THE PATIENT IS		vide the responsible	e party information bel	ow.		NO
o you have someo IF YES, name THE PATIENT IS Re	one that can make med e of surrogate: <u>6 A MINOR</u> , please pro	wide the responsible	e party information bel dian who completes a	ow.	is form.	NO
IF YES, name	one that can make med e of surrogate: <u>6 A MINOR</u> , please pro esponsible party is the	wide the responsible	e party information bel dian who completes a	ow. nd signs thi	is form.	NO
o you have someo IF YES, name THE PATIENT IS Re Last Name Home Address	one that can make med e of surrogate: <u>6 A MINOR</u> , please pro esponsible party is the	ovide the responsible parent or legal guar e City	e party information bel dian who completes a DOB Re	ow. nd signs thi lationship to State	is form. patient Zip	
oo you have someo IF YES, name <u>F THE PATIENT IS</u> Re Last Name Home Address	one that can make med e of surrogate: <u>6 A MINOR</u> , please pro esponsible party is the First Name <u>ATION</u> If name on insur	ovide the responsible parent or legal guar e City	e party information bel dian who completes a DOB Re other than the patient, p	ow. nd signs thi lationship to State	is form. patient Zip e the follow	
o you have someo IF YES, nam <u>F THE PATIENT IS</u> Re Last Name Home Address	one that can make med e of surrogate: <u>6 A MINOR</u> , please pro esponsible party is the First Name <u>ATION</u> If name on insur of Insured	vide the responsible parent or legal guar e City ance card is someone	e party information bel dian who completes a DOB Re other than the patient, p	ow. nd signs thi lationship to State blease provid	is form. patient Zip e the follow	

Amanda Tauscher, MD., FAAD - Jan Marie Kroh, MD., FAAD - Trisha Prossick, MD., FAAD - Jennifer Eyler, MD. Laura Stigge MPA-C - Jesse Watts MPA-C - Retta Kritzer MPA-C - Kristin Sands MPA-C



PRIVACY NOTIFICATION

I have read and/or been offered a copy of the Notice of Privacy Practices for Johnson County Dermatology, PA. I understand that I may request a copy of the Privacy Notification in the future by contacting Johnson County Dermatology PA at (913) 764-1125 or by writing to 153 W 151St St, Suite 100, Olathe, KS 66061.

Signature

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Ple

Date

CONSENT FOR RELEASE OF INFORMATION

Who can we speak with about your medical information, care, and/or billing information?

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

If left blank, we will be unable to speak with anyone other than the patient OR parent/legal guardian of a minor patient. * If you need to make changes to the above preferences, please do so in writing.

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claims and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans, to Johnson County Dermatology for office visits, procedures or hospital charges.

I understand and agree that I am financially responsible for all charges incurred regardless of potential insurance benefits, including but not limited to Co-Payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand that it is my responsibility to verify with my insurance company the physician treating me is covered under my insurance and to get referral(s) and/or authorization(s) for services prior to the service. Further, I understand that services cosmetic or not-medically necessary are not billable to insurance, and I am responsible for paying for those services. Should I have a cosmetic service in addition to medically necessary services during the same visit, I will pay for the cosmetic services, and medically necessary services will be billed to my insurance.

r government reporting purposes.
LANGUAGE English Spanish Indian Russian Decline Other
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