

**R. MAKALA ANDERS, M.D.**

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**PATIENT INFORMATION FORM**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Name (Last, First, Middle Initial)      Date of Birth      Marital Status \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_

\_\_\_\_\_  
Address      SS # \_\_\_\_\_

\_\_\_\_\_  
City      State      Zip      Primary Care Physician

\_\_\_\_\_  
Home Phone      Work Phone      Cell Phone      Pharmacy Name/Location

\_\_\_\_\_  
Occupation      Employer      Employer Address

\_\_\_\_\_  
Email Address

**INSURANCE INFORMATION:**

\_\_\_\_\_  
Primary Insurance Company      Name of Subscriber

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SSN of Parent/Subscriber      Date of Birth

\_\_\_\_\_  
Secondary Insurance Company      Name of Subscriber

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SSN of Parent/Subscriber      Date of Birth

**EMERGENCY CONTACT:**

\_\_\_\_\_  
Name      Relationship

\_\_\_\_\_  
Address      Phone

Do we have permission to discuss your medical condition/health with any person other than yourself? Permission to leave message?    Yes    No

\_\_\_\_\_  
(If yes, whom)      Relationship

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to R. Makala Anders, MD. I understand that I am financially responsible for all charges whether or not paid by said insurance. 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 hereby authorize said assignee to release all information necessary to secure the payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(If under 18 must be signed by parent or legal guardian)

**DO YOU HAVE:**  
A pacemaker?    Yes    No  
Allergies to medications?    Yes    No  
(If yes, please list) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
List current medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Have you previously been diagnosed with skin cancer?    Yes    No  
If yes, circle what type: (melanoma / basal cell squamous cell / unknown)

**Welcome!** My staff and I are fully committed to providing you with the best possible care. We are pleased to discuss professional fees with you at any time. Your clear understanding of our Financial Policy is important to an open trusting relationship with you.

**REGARDING INSURANCE:** Current insurance cards and co-payments are due at the time of your visit. Health insurance is a contractual relationship between you and your insurance company. Thus, the ultimate responsibility of payment for medical service and supplies remains **yours**. We file insurance claims as a courtesy to our patients. However, we cannot become involved in disputes between you and your insurance company. Due to variables and types of plans (i.e. deductibles, share of costs, contractual agreements, etc.), it is the patient's responsibility to know and understand the details of their particular plan/plans. **The patient is ultimately responsible for payment of balances not covered by insurance.**

**FEES:** If it is necessary for Dr. Anders or the Medical staff to perform any treatment (i.e. biopsies, freezings, injections, etc.), these treatments will be charged to you and/or your insurance company, **in addition to**, the initial cost of the office visit/consultation.

**COSMETIC TREATMENTS:** Our office is happy to offer the following cosmetic treatments, including but not limited to: Botox, Collagen, Sclerotherapy (treatment for leg veins). However, these treatments are on a **cash only** basis and are non-refundable.

**PROBLEMS:** If you are having financial problems or have a question about your bill, please call the office. We are always happy to review your charges to be sure they are correct and fair. We will work with you to agree on a reasonable payment schedule, if necessary. We know that you want to keep your account in good standing. If no specific arrangements are made, any account 120 days or older will be referred to an outside collection agency.

**PRIVACY POLICY:** I understand that, under the Health Insurance Portability and 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 among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I may request your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

**I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT AND PRIVACY POLICY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF WHETHER OR NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT.**

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**PATIENT and/or GUARDIAN SIGNATURE**

**DATE**