



Date:

PATIENT NAME (LAST)		(FIRST)	(MIDDLE)	
PHYSICAL ADDRESS		CITY	STATE	ZIP
MAILING ADDRESS		CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX	MARITAL STATUS	
		MALE FEMALE	S M D W	
PHONE NUMBER (CELL)	PHONE NUMBER (HOME)	PHONE NUMBER (WORK)		
IF A MINOR, PARENTS' NAMES (MOTHER)		(FATHER)		
EMERGENCY CONTACT NAME	CELL PHONE	HOME PHONE	RELATIONSHIP	
RACE:	PLEASE CIRCLE ONE: Hispanic/Latino or Non-Hispanic		LANGUAGE:	
<b>EMPLOYMENT INFORMATION</b>				
PATIENT OCCUPATION		WORK PHONE		
PATIENT EMPLOYER				
EMPLOYER ADDRESS		CITY	STATE	ZIP
SPOUSE NAME		OCCUPATION		
EMPLOYER		WORK PHONE		
<b>PRIMARY INSURANCE</b>				
NAME OF SUBSCRIBER		RELATIONSHIP TO PATIENT		
BIRTHDATE OF SUBSCRIBER	SOCIAL SECURITY NUMBER	OCCUPATION		
NAME OF EMPLOYER		WORK PHONE NUMBER		
EMPLOYER ADDRESS		CITY	STATE	ZIP
INSURANCE COMPANY				
POLICY NUMBER		GROUP NUMBER		
<b>SECONDARY INSURANCE</b>				
NAME OF SUBSCRIBER		RELATIONSHIP TO PATIENT		
BIRTHDATE OF SUBSCRIBER	SOCIAL SECURITY NUMBER	OCCUPATION		
NAME OF EMPLOYER		WORK PHONE NUMBER		
EMPLOYER ADDRESS		CITY	STATE	ZIP
INSURANCE COMPANY				
POLICY NUMBER		GROUP NUMBER		
<b>DO YOU HAVE A THIRD/TERTIARY INSURANCE?</b>				
I am consenting to be treated. By agreeing to receive care, I am consenting generally to other medical treatments such as laboratory tests and minor procedures that my physician may order. I understand that co-payments are due at the time of the visit. I authorize the release of any medical information necessary to process my medical claim. I realize that I am responsible for any co-insurance or deductible that my insurance company may apply.				
Signature:		Date:		
I have no insurance and agree to pay my balance in full.				
Signature:		Date:		





## **Integrated Dermatology of Reno-Mortensen, PLLC**

### **Our Financial Policy**

*Here at Integrated Dermatology of Reno-Riley, PLLC dba Aistheta/Reno Medical Skin Care Center it is our mission to provide quality medical care in a professional and caring environment.*

*As a patient, the best action you can take to ensure that your billing is accurate is provide us with current contact and billing insurance information at each visit. With your cooperation, you should be able to receive all the benefits offered to you by your insurance plan(s), allowing our staff to do what they do best – concentrate on your skin care needs.*

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept cash, check, Visa, MasterCard, AMEX and Discover.
2. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will send the bill to you for payment. If we later receive a payment from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them. If your plan has assigned a copayment for your office visit we will collect that at the time of your visit.
4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered” or “not medically necessary” and denies a submitted claim you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
5. If you do not show up for a scheduled appointment or do not provide 24 hours notice to cancel your appointment you will be charged \$35 for each appointment that you "no show". If you "no show" a scheduled surgical appointment you will be charged \$100. This must be paid prior to scheduling your next appointment.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party)

Date

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Please print the name of the patient



William S. Mortensen, MD  
Integrated Dermatology of Reno

## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

### This Consent was signed by:

\_\_\_\_\_  
Printed Name – Patient or Representative

X \_\_\_\_\_ / /  
Signature Date

Relationship to Patient  
(if other than patient):

\_\_\_\_\_

### Witness:

\_\_\_\_\_  
Printed Name – Practice Representative

X \_\_\_\_\_ / /  
Signature Date



William S. Mortensen, MD  
Integrated Dermatology of Reno

## HIPPA Release of Information

Messages regarding office appointments may be left on my:

- Cell phone       Home phone       work phone  
 Email       Sent as text to cell phone

Messages regarding information related to my care may be left on my:

- Cell phone       Home phone       Email

It is okay to discuss my health information with:

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This HIPPA Release of Information was signed by:

\_\_\_\_\_  
Printed Name – Patient or Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to Patient  
(if other than patient): \_\_\_\_\_

\_\_\_\_\_