

PATIENT CONTACT INFORMATION

Dr. Cheryl Kosarek

PATIENT NAME _____ Date _____

May we leave personal medical information on your answering machine at home or on your cell phone?
_____ Yes _____ No

If "No" is checked above, how would you like us to contact you regarding appointment reminders, lab results, etc.?

Do you give our office permission to discuss your medical information / lab results / account information with family members?

_____ Yes _____ No

If yes, please provide their name, phone # and relationship to you below:

- | | | |
|----|--------------------|-------------------------|
| 1. | Name _____ | Phone # (day) _____ |
| | Relationship _____ | Phone # (evening) _____ |
| 2. | Name _____ | Phone # (day) _____ |
| | Relationship _____ | Phone # (evening) _____ |

In case of an emergency, whom should we notify?

Name _____	Phone # (day) _____
Relationship _____	Phone # (evening) _____

WAIVER OF MEDICAL NECESSITY FORM

The following uncomplicated diagnosis are not considered medically necessary by most Insurance Companies and **may not be covered** :

- Seborrheic Keratosis (raised crusty brown “ moles”)
- Dermatitis papulosa nigra (multiple small seborrheic keratosis of the face.)
- Keloids
- Alopecia
- Skin tags
- Milia (white heads)
- Cherry Angiomas (red moles)
- Telangiectasias of the face (small broken blood vessels of the face)
- Lentigos (age spots or liver spots)
- Verruca / warts

*** A Predetermination request or Pre-authorization is required from most insurance companies, and might take 7-10 days for us to get a response for an approval or denial. Please be advised that if you decide to have any of these procedure(s) done on the same day of your consult, you will be required to pay in full , which is completely separate from your office copay. If your insurance does reimburse for the procedure(s) , a refund check will be send to you within 30-60 days.**

The following services are considered cosmetic and **are not covered** by Insurance companies:

- Botox
- Dysport
- Chemical Peels
- Laser Treatments
- Micro dermabrasion
- Removal or treatment of benign asymptomatic growths
- Sclerotherapy for spider/ varicose veins
- Tattoo removal
- Laser hair removal
- Dermal Fillers
- Skin Care Regimens

I understand the services that I am receiving may not be covered by my insurance company. I agree to pay for all fees for any of the above procedures at the time of service. I understand that if my insurance company does ultimately pay for this service, I will receive a refund for any portion not considered “patient liability”.

Date: _____ Signature: _____

My signature below is an acknowledgment that I have read and fully understand the Office Policies.

Patients Name

Parents Name

Parents/Patient Signature

Date

I understand and agree to comply with the Financial Policy of Dr. Cheryl Kosarek. I understand that is my responsibility to pay all charges not paid by my insurance(s) and for the cost of collecting these balances owed, including collection fees and attorney fees.

Patient Name

Date

Signature of Responsible Party

Signature below is only acknowledgement that you have read and understand the Notice of Privacy Practices:

Print Name _____ Date: _____

Signature _____

REMINDERS

**** All co-payments, deductibles, coinsurances, and outstanding balances are due at the time of service. If you have an insurance that we do not participate with, we will collect the full amount of charges for the day's services.**

****If you cannot keep your appointment, we ask you to notify our office at least 24 hours in advance.**

****We do not accept Walk-Ins.**

****A fee of \$25.00 will be assessed to all returned checks.**

PATIENT INFORMATION

Name _____ Age _____
Last First Middle
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Social Security # _____
Home Phone _____ Work Phone _____ Sex: M F
Cell Phone _____ Employer _____
Name of Spouse/Significant Other/Nearest Relative _____ Daytime Phone _____
How did you hear about us? _____
E-mail _____

GUARDIAN INFORMATION FOR MINORS

Guardian # 1
Name _____ Address _____
Relationship to Patient _____ DOB _____ Home Phone _____
Employer _____ Business Phone _____

Guardian # 2
Name _____ Address _____
Relationship to Patient _____ DOB _____ Home Phone _____
Employer _____ Business Phone _____
E-mail _____

INSURANCE INFORMATION

A copy of your insurance card (s) and I.D. will be placed here

I authorize Dr. Cheryl Kosarek and her staff to provide medical treatment to my minor child or me and to furnish information to my insurance carriers concerning my treatment. I hereby assign to Dr. Kosarek all insurance payments for medical services rendered to me or to my dependents. I understand that this authorization will remain in effect for as long as my dependent or I remain a patient. I also understand that I am responsible for any account balance not covered by my medical insurance. I agree to pay the costs of collections including, but not limited to, attorney fee and court costs.

I understand there is a \$25 charge for any returned or missed appointments not cancelled 24 hours in advance.

Signature _____ Date _____