Charles D. Kennard, M.D., P.A.
Mohs Micrographic Surgery for Skin Cancer

Fellow, American College of Mohs Surgery
Fellow, American Academy of Dermatology

PATIENT INFORMATION (Please Print and Use Black Ink)

Patient Name: _____ □ Male □ Female

Social Security #: _____-_____-_____ **Birthdate:** ____/____/_____ **Age:**_____

Race: _____ **Ethnicity:** _____ **Language Spoken:** _____

Street Address (no P.O. box): _____

City: _____ State: _____ Zip: _____

Home Telephone: _____**Cell:** _____

Employer: _____ Work #: _____

Marital Status: **PLEASE CIRCLE ONE:** **Single** **Married** **Widowed** **Divorced**
Spouse's Name: _____ Spouse's Work #: _____

Emergency Contact Not Living with You:_____

Phone #:_____ **Relationship:** _____

Family Physician & Phone #: _____

Referring Dermatologist: _____

INSURANCE INFORMATION

Primary Insurance: _____Insurance Phone #:_____

Name of Policy Holder: _____DOB: _____SSN: _____

Policy/ID#: _____Group #: _____

Claims Address: _____

Secondary Insurance: _____Insurance Phone # _____

Name of Policy Holder: _____DOB: _____SSN: _____

Policy/ID#: _____Group #: _____

Claims Address: _____

INSURANCE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare or insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ **Date:** _____

2001 Rockview Drive
Granbury, Texas 76049
(682) 936-4667 phone (682) 936-4670 fax
www.arlingtonskinsurgery.com

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RELEASE OF MEDICAL RECORDS

Patient Name | Date of Birth | Last 4 digits of SSN

Name and complete mailing address of the person to receive your records is required to process this request. Please include a fax number to expedite your request.

Send copy of records to:

_____

_____

_____

Send Copy of records from:

_____

_____

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

The following information is requested and may be released:

ALL RECORDS	_____	Progress Notes	_____
Slides	_____	Pathology Reports	_____
Operative Reports	_____	Medications	_____
Other	_____		

By checking ALL RECORDS, I hereby give my express consent to release all medical records regarding my treatment, including psychological treatment, drug abuse, alcohol use, human immunodeficiency virus (HIV) infection including acquired immunodeficiency syndrome (AIDS) or tests for HIV, or sexually transmitted diseases.

***Description of purpose of the use and/or disclosure PLEASE SPECIFY:

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Charles D. Kennard, M.D., P.A. in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before receipt of the written revocation. I understand that copies of records are subject to a $25.00 minimum fee.

Signature of Patient or Representative | Date | Daytime Phone Number

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PAYMENT POLICY

We will file your insurance claims for you, but we do require that you pay any copays, deductibles and/or coinsurance at the time of service. At this time we accept cash, checks, money orders, Visa, MasterCard and Discover for payment.

Please read and initial each paragraph:

_____ Mohs micrographic surgery is different from any other surgeries performed when it comes to return appointments. If Dr. Kennard does not perform any type of repair which is called granulation, all return visits for bandaging changes, and/or wound checks will be billed as a nurse visit. If the wound is repaired, your return visit for suture removal is included in the cost of the surgery, and there will be no charge.

_____ ***It is your responsibility to notify our office of any changes in your personal information or insurance coverage prior to your next visit.***

If you have any questions about our payment policy please feel free to contact our office at (817) 460-4444. You may receive a copy of this payment policy upon request.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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Medications

Patient Name: _____ **DOB:** _____

Allergies: _____

Local Pharmacy: _____ **Pharm Phone#:** _____

Medication Name	Strength (mg, g, etc.)	Dosage (Quantity)	Route of Administation	Frequency

Please include ALL vitamins and over the counter medications you are currently taking.

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