KOUBA DERMATOLOGY

PATIENT/ACCOUNT INFORMATION

A. PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH

AGE	SEX	SOCIAL SECURITY NUMBER	MAIDEN/PREVIOUS NAME
	☐ M ☐ F		

ADDRESS	CITY	STATE	ZIP CODE	EMAIL ADDRESS

PHONE NUMBER	EMAIL ADDRESS	MARITAL STATUS	SPOUSES NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE	TYPE
			CELL ☐ HOME ☐ WORK ☐

ADDITIONAL CONTACT	RELATIONSHIP	PHONE	TYPE
			CELL ☐ HOME ☐ WORK ☐

PREFERRED METHOD OF CONTACT

- ☐ CELLPHONE
- ☐ HOME PHONE
- ☐ E-MAIL
- ☐ TEXT

RACE

- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HAWAIIAN OR PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER
- ☐ UNKOWN
- ☐ DECLINED

ETHNICITY

- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ UNKOWN
- ☐ DECLINED

LANGUAGE

- ☐ ARABIC
- ☐ CHINESE
- ☐ ENGLISH
- ☐ FRENCH
- ☐ JAPANESE
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ UNKNOWN
- ☐ DECLINED

B. PERSON RESPONSIBLE FOR PAYMENT- IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH

SEX	SOCIAL SECURITY NUMBER	PHONE NUMBER
☐ M ☐ F		

ADDRESS	CITY	STATE	ZIP CODE	EMAIL ADDRESS

KOUBA DERMATOLOGY

FINANCIAL POLICY

Patient Name _____

Date of Birth _____ Date _____

Kouba Dermatology is committed to providing high-quality dermatologic care, including medical, surgical, and cosmetic services. To ensure efficiency and minimize administrative costs, the following financial policy is in place. By signing below, you acknowledge and agree to these terms:

- **Insurance Participation:**
- Our practice participates with many insurance plans. As a courtesy, we will submit claims for covered services. All required insurance information must be provided prior to leaving the office.
- **Out-of-Network Plans:**
  - If your insurance plan is out-of-network, we will submit claims upon request; however, payment in full is required at the time of service.
- **Patient Responsibility:**
  - Deductibles, co-payments, co-insurance, and any non-covered services are due at the time of visit. Dermatology services (including procedures, pathology, and SRT) may not be fully covered by all plans.
- **Self-Pay Patients:**
  - Patients without insurance are required to pay in full at the time of service.
- **Accepted Payment Methods:**
  - Cash, check, and major credit cards are accepted.
- **Referrals & Authorizations:**
  - It is the patient's responsibility to obtain required referrals or prior authorizations before the visit. Failure to do so may result in rescheduling or full financial responsibility.
- **Insurance Information:**
  - Patients must provide current and accurate insurance information at each visit. Failure to do so in a timely manner may result in claim denial, and the patient will be responsible for all charges.
- **Minors:**
  - A parent or legal guardian is responsible for payment at the time of service. Unaccompanied minors will not be treated for non-emergent services unless prior financial arrangements have been made.
- **Statements & Balances:**
  - Patient statements are issued monthly. Payment in full is due within 30 days.
- **Late Fees:**
  - Balances over 30 days may be subject to a 1.25% monthly finance charge (15% APR).
- **Outstanding Balances:**
  - Patients with outstanding balances may be required to pay prior to being seen and may be subject to discharge from the practice, unless medically necessary care is required.
- **No-Show / Late Cancellation:**
  - Missed appointments or cancellations without adequate notice may result in a fee, which is the patient's responsibility.
- **Collections:**
  - Delinquent accounts may be referred to a collection agency. The patient is responsible for all associated fees.
- **Credit Balances:**
  - Any account credit will first be applied to outstanding balances before a refund is issued.
- **Financial Hardship:**
  - If you are unable to pay your balance, please contact our office to discuss possible arrangements.

For billing or financial questions, please contact our Business Services Department at 419-479-5795.

ASSIGNMENT OF BENEFITS & AUTHORIZATION

I hereby authorize Kouba Dermatology to submit claims to my insurance carrier for services rendered. I authorize the release of necessary medical information, including medical records if required, to process these claims.

I understand that certain information protected by law may require separate authorization for release.

I authorize payment of insurance benefits directly to Kouba Dermatology for services provided.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received or been offered a copy of Kouba Dermatology's Notice of Privacy Practices, which explains how my Protected Health Information (PHI) may be used and disclosed.

I give my permission for Kouba Dermatology to share my health information, verbally or in writing, with the individuals listed below.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I do NOT authorize the release of my health information to any individual other than myself.

PATIENT SIGNATURE

I certify that I have read (or had read to me) and understand this Financial Policy, Assignment of Benefits, and HIPAA Acknowledgment. I agree to the terms outlined above.

Signature of Patient / Authorized Representative: _____

Relationship (if not patient): _____

Date: _____

KOUBA DERMATOLOGY

We are committed to providing the best possible care for you, and we are continually looking for ways to enhance our services.

To assist in our efforts, we may be using AI technology as a tool to aid our providers. AI is artificial intelligence that can assist during patient encounters, generating clinical notes based on our conversations, or during a visit, may offer additional information to the provider on treatment plans, or techniques being used in specific healthcare areas. This allows us to focus more on you, the patient, and less on computer documentation and searching. The AI tool does not interact with you directly. It merely listens to the conversation and creates a summary, or providers the healthcare provider additional information on a specific disease, diagnosis, or symptoms. No search will identify you, the patient specifically.

Your healthcare provider will review and authenticate all documentation in your healthcare record, to ensure accuracy of information.

We want to assure you that your privacy is our utmost priority. The AI tool is compliant with the required, Health Insurance Portability and Accountability Act (HIPPA) guidelines to ensure your data is secure and protected.

I consent to the use of AI technology as needed by my healthcare provider during my medical services.

Patient Printed Name: _____ DOB: _____

Patient Signature: _____

Parent/Guardian Signature (if under 18): _____

Date: _____