JOHNSON DERMATOLOGY
Specializing In Skin Cancer * Providing Comprehensive Skin Care

5921 Riley Park Drive
Fort Smith, AR 72916
Phone: 479-649-3376
Fax: 479-242-2256
www.johnsondermatology.com

At Johnson Dermatology we want to ensure you have the most skintastic experience.

Before your appointment

Please make sure you have turned in the following attached documents via email appointments@johnsondermatology.com or uploaded through the patient portal https://v3.patientwebportal.com/Home/Login

- O JD Patient Registration Form
- O JD Financial & HIPAA Policy (please sign both front and back)
- O Consent for Dermatologic Treatment
- O Copy of your Insurance Card(s)
- O Please call ahead to pay your copay or pay online at https://johnsondermatology.com/pay/

Day of your appointment

- O You are still required to wear a mask to your appointment.
- O Please make sure you are symptom free: no Covid-19 exposure, cough, fever or flu-like symptoms. If you do have any of these symptoms, please call River Valley Health Support hotline 479-289-6508

After your appointment

- O If any concerns or questions arise, please contact us through the portal https://v3.patientwebportal.com/Home/Loginor email nurse@johnsondermatology.com
- O If you have any billing concerns, please email rose@johnsondermatology.com or use the portal https://v3.patientwebportal.com/Home/Login. To pay your bill online please use the link you will receive via text after your statement processes or pay online at https://johnsondermatology.com/pay/

JD Patient Registration Form

For Office Use Only	
Insurance	Registration
□ Entered	□ Entered
□ Scanned	□ Scanned

Patient Information

Full Name: (That appears on your insurance card)			Date of Birth:
Mailing Address or P.O. Box:			
City, State, and Zip Code:			
Social Security Number:			Sex: □Male □ Female
Phone:	Mobile:		Landline:
Employer:			Phone:
Marital Status:	□ Single □ Divorced □ Married □ Widowed	Preferred Language:	□English □ Spanish □Withheld □ Other:
Race / Ethnicity:	□Asian □Black □ Caucasian □Hispanic □Declined □Native American □ Other (please specify):		
Email:			

We encourage you to utilize our Patient Portal. This online tool gives you the flexibility to access your health information and other resources anytime from virtually anywhere. Patient Portal is completely secure, so you can be confident that your private information is protected.

Only you – or an authorized person – can access your Patient Portal account to:
schedule appointments, e-mail your doctor, get lab results, track your health history, request prescription refills

Authorization to Release Health Information

□ By checking this box, I want you to only discuss my healthcare with me.

List any individuals with whom we can discuss your care – for example, your spouse or child.

Person One	Name:	Date of Birth:
	Phone Number:	
	Relationship to Patient:	
Person Two	Name:	Date of Birth:
	Phone Number:	
	Relationship to Patient:	
Person Three	Name:	Date of Birth:
	Phone Number:	
	Relationship to Patient:	

JD Patient Registration Form

Other Household Members: List any household members seen at Johnson Dermatology – for example: spouse, parent or child.		
Person One	Name:	Date of Birth:
Person Two	Name:	Date of Birth:

Parent or Guardian Information

(complete only if the patient is less than 18 years old or you have a POA for patient)

Full Name:		Relationship:
Address:		
Social Security Number:		Date of Birth:
Phone:	Home:	Mobile:
E-mail Address:		

Primary Insurance Information

Insurance Carrier:	ID:
Subscriber:	Relation to Patient:
Social Security Number:	Date of Birth:
Employer:	Phone:

Secondary Insurance Information

□ Check if Not Applicable.

Insurance Carrier:	ID:
Subscriber:	Relation to Patient:
Social Security Number:	Date of Birth:
Employer:	Phone:

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Consent for Dermatologic Treatment

At Johnson Dermatology your healthcare provider may perform routine dermatologic procedures in the treatment or diagnosis of your skin condition. These procedures may include the following:

- Destruction with Liquid Nitrogen - freezing spots with cold spray to get rid of them – multiple treatments may be needed.
- Shave Removal/Skin Biopsy with a Blade – numbing a spot with a shot then shaving it off with a razor blade and sending it for pathology testing
- Excision or Skin Biopsy with a Punch Tool – numbing a spot with a shot then using a punch tool that looks like a cookie cutter to remove a piece of skin. The skin is sent for pathology testing, and the hole is left to heal on its own or sewn together with stitches.
- Other Procedures
  - scraping or swabbing of the skin surface to take a sample
  - injection of medication into the skin or muscle
  - prescriptions for pills or creams
  - nail removal or biopsy

Any treatment or procedure has associated risks. The usual risks associated with the above treatments include the following:

- Scar
- Infection
- Medicine Side Effects
- Bleeding
- Increased Cost
- Treatment Failure
- The test may not be able to give a specific answer.
- The test result may be wrong.

I give my permission for my healthcare provider to perform any of the above listed treatments and any other treatments that I may need. I understand the risks associated with treatment. I understand treatments that are not FDA approved or considered "off-label" may be used. I understand that I can at any time refuse treatment and can ask questions about my treatment if I do not understand what is happening. This consent will be considered valid until it is revoked by the patient or guardian in written form.

_____ _____

Printed Patient Name Code

_____ _____

Signature of Patient or Guardian Date

A carbon copy of this signed form was given to the patient.

Johnson Dermatology Consent Form

I. Consent to Treatment

I voluntarily consent to receive medical and health care services that may include examinations, diagnostic procedures, and treatments. If patient is under the age of 18, or over 18 and are unable to consent for themselves, I give permission for the patient to receive follow-up care from the physicians and staff at Johnson Dermatology Clinic in my absence. I also understand that any copays/fees for services the patient receives is due at time of service.

II. Assignment of Benefits

I authorize my insurance company to make direct payment to the provider of services for the professional or medical expense benefits allowable under my current insurance policy. I authorize appeals to be filed to my insurance company if needed. I understand that if my insurance company is out-of-network, open or a nontraditional plan, Johnson Dermatology will provide a claim form so that I may file on my insurance and I will be responsible for payment in full at time of service.

III. Financial Responsibility

I agree to pay all charges for medical or other services not covered by my insurance company. I further understand that I am responsible for all collection and/or attorney fees necessary to collect this debt as governed by the Johnson Dermatology Financial Policy on the reverse side. In the event that Johnson Dermatology has made reasonable attempts to file claims to the insurance company for which I have provided information and direct payment is not received within 60 days of the date of service, I may be fully responsible for charges incurred.

IV. HIPAA Consent

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that governs the use and disclosure of a person's health information. The following statements cover the basics of your rights as a patient under HIPAA.
I acknowledge I have received a copy of the Notice of Privacy Practices. Johnson Dermatology reserves the right to change the Notice of Privacy Practices.

By my signature I certify that I have read the four sections above, and agree to the above statements.

Patient Name (please print): _____

Authorized Rep: _____ Relationship to Patient: _____

Signature: _____ Date: _____
(Signature of Patient or Authorized Representative)

Revised Jan 26, 2021

Johnson Dermatology's Financial Policy

Johnson Dermatology is committed to serving our patients with efficient, quality, compassionate, comprehensive, patient-centered skin care. We expect a great relationship with our patients as well as prompt payment for services. You are ultimately responsible for your bill.

Payment is required at time of service for cosmetic and non-insurance covered services, patient pay services, co-payments and deposit towards unpaid deductible is required.

Accurate and complete information concerning your primary and secondary insurance, including referral documents from other providers must be provided at time of service.

- As a courtesy, JD will file your primary & secondary insurance claim when presented at time of service. We will not file tertiary insurance.
- Johnson Dermatology's willingness to file to the insurance presented does not guarantee the facility or provider is currently listed as in-network status with the carrier.
- If no insurance card is presented at time of service or we are unable to verify coverage, a minimum payment of $100.00 and credit card on file will be required.
- All accounts for a household will be linked together.

There is a fee of $100.00 for missed as well as reschedule or cancelled appointments with less than a 24 hour notice. $200 for missed surgery or cosmetic appointments.

- If you have already missed an appointment, a deposit or CCOF is required to schedule another appointment.

All reasonable attempts will be made to obtain payments for services.

- Payment in full is due upon receipt of electronic statement unless arrangements are made with the billing office.
- One electronic statement will be sent.
- One phone notification via automated system.
- If payment is not received, the balance will be sent to an outside collection agency which could cause accrual of additional fees of 30-50% of the account balance. The patient will be blocked from further clinic services.

You may request a credit card be kept on file (CCOF). I authorize Johnson Dermatology to keep the credit card on file ending in the last 4 digits:_____exp:_____as a convenient method of payment for the portion of services that my insurance does not cover or for missed appointment fees. Credit card information is kept confidential and secure. This authorization will remain in effect until I cancel this authorization.

The financial policy will be enforced by all clinic personnel. Please direct any concerns or questions to Shelly Sparrow (Clinic Manager) and Rose Shoffey (Billing). rose@johnsondermatology.com.

By my signature I certify that I have read the four sections above, and agree to the above statements.

Patient Name (please print): _____

Authorized Rep:_____Relationship to Patient: _____

Signature:_____Date: _____

Revised Jan 26, 2021