DERMATOLOGY OF SOUTHERN KENTUCKY, PLLC
BRIAN L. BAKER, MD
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SOMERSET, KY 42503
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FAX: 606-677-0335

Patient Name:_____

Welcome to Dermatology of Southern Kentucky. We appreciate your business and will do our very best to provide the highest level of dermatologic care available. Please read the following office policies, complete the enclosed forms, and bring them to your first appointment. We ask that you arrive 10 minutes prior to your scheduled time.

It is your responsibility to confirm our participation with your insurance plan, and to find out if a referral or prior authorization is required from your primary care doctor. We will be happy to assist you in any way possible, though the best approach is for you to call your insurance company directly. Please bring your insurance card to your appointment. Co-payments are due on the day of service, as required by our contract with your insurance company. Patients without insurance and those receiving cosmetic or non-medically necessary treatment will be responsible for payment on the day of service. We accept cash, personal check, and some credit cards. A $20.00 service charge will be assessed for all returned checks. After the claim has been processed by your insurance company, we will bill you for any amount still owed. Delinquent balances over 90 days old will be referred to an outside collection agency.

Children under 18 years of age must be accompanied by a parent or legal guardian. Office policy is to obtain verbal consent before simple office procedures (biopsy, cryosurgery, destruction, small excisions, etc) and written consent for more complex procedures such as Mohs surgery and reconstructions. Pathology (biopsy interpretation) services may be performed by one of our physicians or by an independent pathologist or lab. These services are not included with office visits and procedures, and will be billed to you and/or your insurance company accordingly.

If you will not be able to keep your appointment, please cancel with 24 hours notice. We realize that unforeseen circumstances do arise, and will allow any patient who has “no-showed” only one time to reschedule.

We may use or disclose your protected health information to carry out your medical care, to obtain payment from your insurance company, or to conduct health care operations such as quality reviews. We have the right to change our privacy practices. You may obtain any revised notices at the clinic. You have the right to request a restriction of how your protected health information is used. If we agree to your requested restriction, we will follow the restriction(s). You may revoke this consent at any time by making a request in writing, except for information already used or disclosed. Photographs are used only for in-office documentation and will not be shared, posted, or used for teaching without your permission.

Please sign below to indicate that you understand and agree to our office policies, as well as to verify that you have read our current Notice of Privacy Practices posted at the check-in window. Your signature also indicates your permission for us to correspond with your spouse, parent, or child regarding test results and scheduling of appointments.

Signature:_____ Date:_____
If signed by patient representative, state relationship to patient:_____