martha e. stewart, md, llc
dermatology

4060 lonesome road, mandeville, la 70448 985.727.7701

martha e. stewart, md
board certified dermatologist

olivia a. gioe, md
board certified dermatologist

REGISTRATION FORMS (please print)

PATIENT

First Name: _____ Middle: _____ Last: _____ Date of Birth: _____

Referred By: _____ Primary Care Physician (PCP): _____

Email: _____ Name for email: _____

Would you like to receive emails and/or texts about our monthly cosmetic promotions and flash sales?
Sign up for emails on our website at **www.drmarthastewart.com** **AND**
Provide cell phone number for texts: _____

Would you like to learn more about the skin care products and cosmetic procedures that we offer?

We offer a complimentary skin care consultation with our aesthetician. Please schedule at the front desk if you are interested.

If you have Medicare:

Have you seen your PCP in the last 6 months? _____ **YES** _____ **NO**

PERMISSION TO DISCUSS INFORMATION

Do you give our office permission to discuss your medical information (i.e. all health information, appointments, your medical condition, treatment, test results, prescriptions) with a family member?

(Please initial one) **YES** _____ **NO** _____

☐ If **YES**, please provide the following information:

Name: _____ Relationship: _____ Phone#: _____

By providing my signature below, I acknowledge that all information I have submitted on this form is correct.

_____

Signed By: Patient or Legal Guardian, if a minor Date

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OFFICE POLICIES

BILLING AND INSURANCE: It is your responsibility to know and understand your insurance plan's policies. There are a number of different insurance plans and each one has its own unique reimbursement policies. It is your responsibility to notify us of any special requirements within your plan. We accept most insurance plans and will file all claims, including secondary insurance, to the plans with which we participate.

All co-payments and deductibles are collected at the time of service. If you have not met your deductible, we require that you pay a percentage of the contracted fee amount at the time of service. You will receive a bill for the remaining balance. It is important to understand that most insurance companies consider all procedures (i.e. freezing warts, biopsies, etc.) applicable to your surgery deductible (if you have one). If your insurance company denies your bill, you will be held financially responsible. If you have no insurance or if you are having a cosmetic procedure done, the fees will be collected in full at the time of service. If your insurance changes, it is your responsibility to notify our office at least 24- hours before your appointment to make sure we are a provider. Failure to do so may result in needing to reschedule your appointment and a $35 cancellation fee.

You may receive a separate bill for any laboratory tests or pathology services that Dr. Stewart or Dr. Gioe may order.

PAYMENT: We accept the following forms of payment: personal check, cash, MasterCard, Visa, American Express, and Discover.

RETURNED CHECK FEE/COLLECTIONS: There will be a $35.00 charge for all returned checks. If it is necessary to collect unpaid fees for services rendered, you will be responsible for the charges assessed by the collection service, legal counsel, or court.

UNACCOMPANIED MINORS: At all initial visits, minors must be accompanied by a parent or legal guardian. Thereafter, if a minor is attending an appointment without a parent, payment is still expected at the time of service. Please provide written consent for all unattended minors - Parental Permission Form for Minors.

LATE POLICY: Our physicians and staff strive to be on time. In order to help our office run smoothly, we ask that you do the following: If you are running more than 15 minutes late, please call to let us know as we may need to reschedule your appointment.

MISSED APPOINTMENTS: If you need to cancel or reschedule an appointment, we kindly request that you give our office 24-hour notice. If we do not receive 24-hour notice, there will be a cancellation fee billed to the patient or responsible party. This fee will be waived with the first occurrence. Thereafter, the cancellation fees are as follows: $35 for a regular appointment and $75 for all surgery, filler, Botox, or laser appointments. Please note: Patients who continually miss their appointments without giving proper notice to our office staff will be discharged from the practice after the third violation.

GIFT CERTIFICATES

- Gift Certificates MUST be present at the time of service.
- Gift Certificates are nonrefundable and nontransferable.
- Gift Certificates can only be used for our aesthetician's services.
- Martha E. Stewart, MD, LLC is not responsible for lost or stolen Gift Certificates.
- Gift Certificates are valid for one year from the date of purchase.

HAVE A QUESTION? We request that any medical correspondence, including prescription refill requests, be through our **patient portal**. The portal keeps your personal health information secure and private. You can easily access your portal at the top of our website under "**Patient Portal.**" Use your login information that you received at your visit. If you do not have this information, please contact our office at 985-727-7701, and one of our staff members can assist you with your login. If you are a new patient, you will be given access and login information at your office visit.

I have read and understand the financial policy of the practice and I agree bound by its terms.

_____

Signature of Patient or Responsible Party

_____

Print Name Date

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ACKNOWLEDGEMENT OF RECEIPT OF NONDISCRIMINATION POLICIES AND NOTICE OF PRIVACY PRACTICES

By providing my name below, I hereby acknowledge that I have reviewed the Nondiscrimination Policies and Notice of Privacy Practices, describing the privacy practices and safeguards as well as my rights with respect to my protected health information maintained and used by Martha E. Stewart, M.D., L.L.C.

By providing my name below, I hereby declare that I have honestly and completely answered the questions that were asked in this form to the best of my knowledge. I understand that it is my responsibility to notify Dr. Martha E. Stewart, Dr. Olivia A. Gioe, and/or the staff of Martha E. Stewart, MD, L.L.C of any changes in insurance coverage, personal information, my medical condition, or medication during the course of my treatments or follow up visits.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Martha E. Stewart, M.D., L.L.C., or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or Insurance payments of medical benefits be made to Martha E. Stewart, M.D., L.L.C.

GUARANTOR RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Martha E. Stewart, M.D., L.L.C, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.
This authorization and assignment may be revoked by me at any time by a written notice.

I agree that a photocopy of this form may be used in lieu of the original.

By providing my signature below, I acknowledge that all information I have submitted on this form is correct.

Signed By: Patient or Legal Guardian, if a minor _____ Date _____

Print Name _____ Date _____