Please present your insurance card(s) and a photo ID
to the receptionist along with this completed form. Thank you.

Today's Date ____/____/______

Full Name____

*****PLEASE FILL OUT NAME AS IT APPEARS ON YOUR INSURANCE CARD*****

Preferred to be called:__________________ □ Employed □ Retired □ Full-time student □ Other

Address:____Apt:___________________

City:___________________________State:___________Zip code:_________________________

Home#_____________________Cell#_____________________Work#________________________

Date of Birth: ____/____/______ Sex: □ Male □ Female Marital Status: □ M □ S □ D □ W

SS#___________________________E-MAIL:____

Patient Employer:___________________________Occupation:____________________________

Spouse Name:_____________________________ Work#__________________________________

Employer:_________________________________Occupation:_____________________________

IF PATIENT IS A MINOR OR A STUDENT PLEASE FILL OUT THE FOLLOWING:

Father's name:_____________________________Work#__________________________________

Employer:________________________________ Occupation:_____________________________

Mother's name:____________________________ Work#__________________________________

Employer:________________________________ Occupation:_____________________________

Primary Care Physician ___________________________Phone#____________________________

In case of Emergency, who should be notified?____

Relationship to patient: ___________________**Phone#**___________________________________

How were you referred to our practice?

□ Physician □ Patient □ Advertisement □ Other

Name of referring party:____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:______________________________

Address for medical claims:______________________________

Phone number for member/customer service:______________________________

Policy #:______________________ Group#:______________________

Policy Type: □ HMO □ PPO □ POS □ Indemnity

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:______________________________

Address for medical claims:______________________________

Phone number for member/customer service:______________________________

Policy #:______________________ Group#:______________________

Policy Type: □ HMO □ PPO □ POS □ Indemnity

Are you interested in cosmetic procedures?

□ Botox®	□ Chemical Peels	□ Skin Care Analysis
□ Spider Vein Treatment	□ Brown spot Removal	□ Laser Hair Removal
□ Skin Care Products	□ PhotoRejuvenation	□ Dermal fillers

My signature below indicates that I voluntarily consent to receive medical, health care and/or cosmetic services that may include diagnostic procedures, examinations and treatment.

My signature below indicates that I have reviewed and/or have access to a copy of my physician's Notice of Privacy Practices.

______________________________Date:______________________

Patient, legal guardian or responsible party signature:

I hereby acknowledge that all of the above information is complete and accurate.

______________________________ Date:______________________

Patient, legal guardian or responsible party signature:

Dermatology Consultants, PC
Financial Policy

For your convenience, we accept Visa, MasterCard, Discover and Checks.

It is imperative that a current copy of your insurance card is provided for accurate billing. It is extremely important for you to educate yourself about your individual insurance benefits. **Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan. Our office can never guarantee coverage for any service provided by our office. If you are unsure of your coverage benefits, call the customer service number on your insurance card.** 75% of the charges in dermatology are considered "in-office surgery"; most insurance plans have a deductible, which you are responsible for paying. It is the policy of this office that the adult presenting a minor for treatment is responsible for payment of the patient portion at the time of service.

Return check fee $30.00

If you are turned over to our collection agency, your account will be assessed 38% of the balance due.

Labs: Our office utilizes outside facilities for blood work, biopsies, cultures, etc. Insurance/billing is handled separately by these facilities. You will receive a separate explanation of benefits from your insurance carrier. You may also receive a separate bill from the lab, depending on the benefits of your plan.
Medicare patients: We are participating providers of the Medicare Part B program. We will accept assignment on all claims. Patients are responsible for meeting their annual $135.00 deductible and paying for the 20% copayment. Our office will file your secondary/supplemental carrier claims. However, in the event that the secondary does not pay, patients will be billed for the balance.
Medicare 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 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
Supplemental Authorization: (Medicare patients)
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.
HMO, POS, PPO, Commercial or other managed care patients: You will be responsible for paying your annual deductible, copayment, coinsurance and charges for any non-covered, cosmetic services or over-the-counter products at the time of the visit.
Out of Network insurance carriers: We will file claims for patients covered by private or commercial plans in which our physicians are not contracted providers. Please be aware that charges are not subject to any sort of contractual deduction. Additionally, we have no contractual relationship with these carriers; we are unable to appeal any adverse claims decision. Any outstanding balance is the responsibility of the patient or guarantor.

I have read the financial policy, and I understand and agree to this policy.

____ ______________________

Patient, legal guardian or responsible party signature Date