

Patient Information

Name: _____ Date of Birth: _____ Email: _____
 Address: _____

 Phone No: _____ Home Work Cell
 Phone No: _____ Home Work Cell

Primary Care Physician: _____ Social Security #: _____

Address: _____ Referring Physician(if different than Primary Care Physician)

Phone No: _____
 Pharmacy/Phone #: _____ Phone #: _____

How did you hear about our clinic? Yellow Pages Advertisement Friend _____ Website Other: _____

Financially Responsible Party

() Same as Patient

Name: _____ Relationship: _____

Address: _____ Emergency Contact/Phone No: _____

Primary Insurance

Ins Company: _____ Subscriber: _____

Policy #: _____ Date of Birth: _____

Group #: _____ Relationship to Insured: _____

Employer: _____ Active Retired Cobra

Secondary Insurance

Ins Company: _____ Subscriber: _____

Policy #: _____ Date of Birth: _____

Group #: _____ Relationship to Insured: _____

Employer: _____ Active Retired Cobra

If you wish to have you medical information disclosed to another family member in your absence (i.e. Biopsy Report or lab reports), please list their name and relationship to you below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X _____
 Patient Signature Date

X _____
 Responsible Party (if the patient is under 18 years of age) Date

CENTER FOR DERMATOLOGY AND LASER SURGERY, PC

PATIENT FINANCIAL POLICY and NOTICE OF PRIVACY PRACTICES (HIPAA)

Patient Name: _____ Today's Date ____/____/____

RECEIPT OF PRIVACY PRACTICES:

My signature below indicates that I have received (upon request) and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ **Date** ____/____/____

FINANCIAL POLICY:

Self Pay: All patients will be required to pay \$135.00 deposit at the time of service. All additional charges will be billed directly to you with payment due in full within 30 days from date of service.

Insurances: Patients are required to bring their current insurance identification card to *each* appointment. It is your responsibility to inform us of any changes in insurance, address, or telephone number. If your insurance information is not received within 3 business days of your appointment, the balance incurred from your visit will be your responsibility and your insurance will not be billed. _____ **Initial if card not present**

HMO/PPO Plans: HMO/PPO co-payments are due at the time of each visit. If a co-payment is not received at the time of your visit there will be a \$25.00 billing fee added to your account. You will be responsible for paying your annual deductible, co-insurance, co-payment and charges for all non-covered services.

Medicare: We accept Medicare assignment and will bill your secondary insurance for you. You are responsible for paying your deductible, co-pay, co-insurance, and any amount not paid by Medicare or your secondary insurance.

Commercial Plans: Patients who are covered by a private plan in which our physicians are not providers will be required to pay \$135.00 deposit at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Cosmetic Procedures: Payment for all cosmetic procedure is due at the time of service. You will be provided with a cost estimate prior to the procedure.

Returned Check: In the event we receive a returned check, due to insufficient funds, we will charge a \$25.00 fee to your account. Payment will be due in full immediately upon notification.

Collection Agency Fee: If your account balance is turned over to an outside collection agency a \$25.00 processing fee will be added to your balance.

IMPORTANT NOTE ABOUT YOUR INSURANCE BENEFITS:

Please be sure to check your insurance benefits. Treatments and procedures recommended for you are considered by your insurance company as a separate charge from the office visit with the physician, even if the appointment occurs on the same day as your appointment with the physician. Usually, co-pays and deductibles apply to these types of appointments. For specific questions regarding your insurance policy guidelines, please contact your carrier's customer service department.

I have read and agree to abide by the policies set forth in this document.

Patient or Responsible Party Signature

____/____/____
Date