DERMATOLOGY & SKIN CANCER CENTERS

PATIENT REGISTRATION FORM

PLEASE PRINT.

Write N/A in the blanks that do not apply to you.

PATIENT INFORMATION

Name: ______________________________________ Date of Birth: __________________ SSN#: ____________________

Address: ____ City: _____________________ State: _____ Zip: __________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ________________________

Best hours to contact: _____________ Email Address: ______________________________________ (will only be used by the Practice)

Marital Status: Single Married Widowed Sex: Male Female Student Status: N/A Full-time Part-time

Employer: _________________________________ Primary Care Physician: ____________________________________

Drivers License#: ______________________ State Drivers License was issued: _____

Race: American Indian/Eskimo/Aleut Asian or Pacific Islander Black White Other

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Preferred Language: ______________________

SPOUSE, PARENT, LEGAL GUARDIAN INFORMATION

Relationship to Patient: _________________________

Name: ______________________________________ Date of Birth: __________________ SSN#: ____________________

Address: ____ City: _____________________ State: _____ Zip: __________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ________________________

Employer: ____

Address: ____ City: _____________________ State: _____ Zip: __________

INSURANCE INFORMATION

Please note we only file on two policies.

Primary Insurance Company: _______________________________ Policy #: _______________________Group #: _____________

Insurance Claims Address: _____________________________ City: ______________________ State: ____ Zip: _______

Name of Policy Holder: _________________________________ Relationship to Patient: ________________________

Date of Birth: ________________ SSN#: ____________________

Address: ____ City: _____________________ State: _____ Zip: __________

Secondary Insurance Company: ______________________________ Policy #: _______________________Group #: ___________

Insurance Claims Address: _____________________________ City: ______________________ State: ____ Zip: _______

Name of Policy Holder: _________________________________ Date of Birth: ________________ SSN#: ____________________

Address: ____ City: _____________________ State: _____ Zip: __________

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EMERGENCY CONTACT *Please be aware that by listing this person, you are giving Dermatology Associates permission to release your medical information to them in the event of an emergency.*

Name: ____________________________ Date of Birth: __________________ Relationship to Patient: _________________________

Address: ____ City: _____________________ State: _____ Zip: __________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ________________________

PARTY RESPONSIBLE FOR PAYMENT (if other than self) Relationship to Patient: _________________________

(Please note this person must sign the financial policy form.)

Name: ______________________________________ Date of Birth: __________________ SSN#: ____________________

Address: ____ City: _____________________ State: _____ Zip: __________

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ________________________

Employer: ____

Consents are required for you to be seen by our providers, so please review and initial below.
If you have any questions or need explanations, one of our staff members can assist you.

_______ *(Initials)* **Consent for Treatment:** I authorize Dermatology & Skin Cancer Centers to provide any healthcare services that my provider deems necessary for treatment and/or diagnosis including biopsies. I also understand that, in the course of that treatment, photographs may be taken for clinical purposes. If photographs will be used for commercial or educational purposes, I will be provided an additional authorization. No videotaping or photography is allowed by non-staff members.

_______ *(Initials)* **Consent for Filing Insurance Claims:** I understand that, in order to file claims and release medical information to any insurance company(s) I have listed in my financial record, Dermatology & Skin Cancer Centers is required to keep my signature on file. I hereby authorize Dermatology & Skin Cancer Centers to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize Dermatology & Skin Cancer Centers to appeal any denial to my insurance company on my behalf and authorize the release of any medical information to my insurance company(s) that is necessary for the processing of claims.

_______ *(Initials)* **Consent for Appointment Reminders:** I understand that Dermatology & Skin Cancer Centers will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I further understand that I will have the option to opt out of future text/email reminders.

_______ *(Initials)* **Consent for Electronic Prescription History:** I understand that, in order to offer the best patient care, Dermatology & Skin Cancer Centers will retrieve my prescription history that has been ordered and filled through Surescripts. I authorize Dermatology & Skin Cancer Centers to import the prescription history obtained through Surescripts into my electronic chart.

_______ *(Initials)* I hereby state that the above information is true and correct to the best of my knowledge.

____ ____________________ ____________________

Print Patient Name **Date of Birth** **Date**

DERMATOLOGY & SKIN CANCER CENTERS

Financial Policies

This document provides you with the Financial Policies used by Dermatology & Skin Cancer Centers.
Your signature and initials are required on this form in order to be seen by any of our providers.
If you have any questions or need explanations, please ask a staff member.

Consent to Pay for Services Rendered: Payment is required for all services at the time the services are rendered. Our doctors accept Medicare and many commercial insurance plans. Medicare will forward claims to most secondary payers. If we are contracted providers (in-network) with your insurance plan, we are required by contract with your insurance company, to collect your co-payment(s)\co-insurance and any unmet deductible at the time of service. For patients with private insurance with whom we have no contract (out-of-network), you will be required to pay for your services at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider and to understand your coverage benefits under your policy. Insurance coverage is not a guarantee of payment by your insurance company. If your insurance company fails to respond or does not pay promptly, we will forward the balance to you for payment. Should your insurance company pay after you have already paid us, we will promptly refund you any overpayment due to you. We accept Visa, MasterCard, Discover American Express and Care Credit for your convenience. If you have a bonafide hardship, please ask to speak to a patient account representative, so that we may work with you.

Please read and initial the following specifics regarding our payment and collection processes.

______*(Initials)* I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare and/or my supplemental policy. This also includes cosmetic services not covered by insurance. Please contact your insurance company for this information.

______*(Initials)* I understand that procedures performed in the office are often separate billable services that are not included in the office visit. I understand that many insurance companies apply these procedures to a deductible or co-insurance and may not be covered under the co-payment. I will be responsible for any unmet deductible or co-insurance at the time of service. It is my responsibility to know and understand what my policy benefits are with my insurance company.

______*(Initials)* I understand that if I have a surgical procedure or biopsy done at Dermatology & Skin Cancer Centers, there are two charges. First is the provider charge for collecting the Biopsy and the second is a charge to examine the specimen by a Pathologist, chosen by my attending Physician. Because Pathologists are also medical doctors, I will be billed separately for these pathology charges by the Pathologist who does the reading.

______*(Initials)* I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory company I need to use. It is my responsibility also to inform my provider of this at the time services are rendered.

______*(Initials)* We refer delinquent accounts to an outside collection agency. If it became necessary to refer your account to a collection agency a collection fee of up to 30% of your balance due plus an administrative service fee of $25 will be assessed to your account. In addition, you would no longer be able to make appointments for yourself or your immediate family members until such amounts have been paid in full.

______*(Initials)* I understand that my listed phone information will be used for collection efforts in any capacity including initiated by an autodialing system and that at a later date I can opt out.

______*(Initials)* I understand that a $25 returned check fee will be assessed to my account for any checks returned by my financial institution. I also understand that payment of the check and fee will be due immediately and I will no longer be able to issue a check as payment to the practice.

______*(Initials)* I have read the above stated financial policy and agree to meet my financial obligation in accordance with this policy.

____ ____________________

Print Patient Name **Date of Birth**

____ ____________________

Signature Patient or Legal Guardian/Responsible Party **Date**

Credit/Debit Card Authorization Policy

Our financial policy requires that a credit or debit card be placed on file prior to being seen by our providers. This allows us to provide ease of payment once your account has been settled and you have been notified of the balance. Co-pays are not included in this process and they are collected at the time services are rendered.

We will file your claim to your insurance company. After your insurance company processes your claim, Dermatology & Skin Cancer Centers will mail a statement to the address on file that will provide you with your current balance. Your payment will process on the due date indicated on your statement. Should you elect to pay in monthly installments or have questions concerning your bill, you must contact our business office before the due date listed on the statement.

The security of your information is very important to our practice. Your credit card information is stored by our credit card merchant company, who specializes in this process. Our staff has no access to your card information. No personal medical information is stored with this company.

PLEASE SIGN: I authorize Dermatology & Skin Cancer Centers to charge my credit or debit card for balances due for services rendered. I understand that Dermatology & Skin Cancer Centers will send me a statement with my current balance due. If I choose to pay my balance in monthly installments, then I will contact Dermatology & Skin Cancer Centers business office prior to the due date on my statement to establish those arrangements.

____________________________________ ____________________________________

Print Patient Name Date of Birth

____________________________________ ____________________________________

Patient or Legal Guardian Signature Date