CENTER FOR Dermatology & Plastic Surgery

PATIENT INFORMATION

Appointment Date:

MRN #:

Patient Name: **Nickname:**

SSN: **DOB:** **Marital Status:** **Gender:**

Primary Address:(for billing and other correspondence) ,
Secondary Address:

City: **State:** **Zip:**

Race: □ White/Caucasian □ American Indian □ Asian □ Black/African American □ Other_____ **Language:** □ English □ Other_____ **Ethnicity:** □ Hispanic/Latino □ Not Hispanic/Latino

WHEN CENTER FOR DERMATOLOGY AND PLASTIC SURGERY HAS TO CALL:

PLEASE NOTE: ALL numbers listed below are subject to phone or text confirmation for upcoming appointments and post-appointment surveys

What number do you want called **1st:** _____ □ Home □ Cell □ Work □ Other_____
What number do you want called **2nd:** _____ □ Home □ Cell □ Work □ Other_____

PLEASE NOTE: The numbers listed above are also subject to messages from our office

Primary Care Physician (PCP):
(Please list physicians first and last name- NOT facility) **Phone Number:**

Referring Physician (If any):
(Please list physicians first and last name- NOT facility) **Phone Number:**

What email address do you want to use for appointment confirmations, post-appointment surveys, newsletters, and your online patient portal:

How did you hear about our office:
□ Church Bulletin □ Internet/Search Engine □ Magazine _____
□ Insurance Company □ News Segment □ Patient Referral _____ □ Physician Referral □ Real Self □ Sign
□ Social Media □ Website □ Word of Mouth □ Other_____

May we discuss scheduling, Billing and/or your medical condition with any member(s) of your household:

If "Yes", whom(LIST ALL) **Relationship:**

Emergency Contact:
(If different from above) **Phone:** **Relationship:**

Parent/Responsible Party:
(If the patient is a minor) **DOB:** **Relationship:**

Responsible Party Address:
(If different from patient) **SSN:**

Primary Insurance Name: **Policy #:** **Group #:**
Subscriber/Policy Holder: **DOB:** **SSN:**

Secondary Insurance Name: **Policy #:** **Group #:**
Subscriber/Policy Holder: **DOB:** **SSN:**

BY SIGNING THIS FORM I CONSENT TO BE TREATED AT CENTER FOR DERMATOLOGY & PLASTIC SURGERY

PAYMENT POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay for any non-covered services and co-payments. In the event that your account becomes delinquent, a $25 late fee may be added to your account. Returned checks will incur a $25 additional fee. If your account becomes delinquent and we are unable to collect, your account will be sent to collections, and you will be responsible for your balance plus the collection fee of up to 50% of your balance.

CANCELLATION AND NO-SHOW POLICY

We ask that you give at least 24 hours notice in the event that you must cancel your appointment. All appointments cancelled within 24 hours will be considered "No Show." "No Show" will result in a $50 fee ($75 fee for cosmetic/surgeries), per instance, added to your account. We don't bill for preventive care. It is the responsibility of the patient(s) to obtain referrals.

AUTHORIZATION TO RELEASE INFORMATION AND RECEIVE PAYMENT

I authorize the release of medical information to my primary or referring physician, to consultants, if needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician.

By signing below, I acknowledge that I have read, understand, and agree to the Notice of Privacy Practices and Office Policies:

Patient or Parent/Guardian Signature: Date: