PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

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

In case of an emergency, who should be notified?_____Phone(_____)_____

RELEASE OF INFORMATION:

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

PAYMENT POLICY:

Notice to all patients: In the event that your account must be turned over to collections, a collection fee will be added to your account.

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO, PPO or other mananged care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the 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.

MEDICARE PATIENTS:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

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.

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically " crosses over ", we are required to keep a separate signature on file:

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.

Patient or Responsible Party Signature_____**Date**____/____/____

Name_____

Reason for visit (rash, lesion, mole, acne, itch, skin cancer, skin check, etc.):

_____

_____

_____

Since your last visit:
New diagnosis:_____

New surgeries:_____

New medicines (do not fill out if you brought a medication list):

_____

_____

New drug allergy:_____

Do you smoke? Yes No

ALERTS: PLEASE CIRCLE ANY THAT APPLY TO YOU:

Artificial heart valve
Heart valve defect
Defibrillator
Premedication recommended prior to procedures
Latex allergy Describe_____
Blood thinners What type?_____

Pregnant
Breast-feeding
Lidocaine (Xylocaine) allergy
Epinephrine allergy
Organ transplant