

The Center for Dermatology Care  
Patient Information Sheet  
(Please print or write legibly)

Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Last Name First Name MI

Date of Birth: \_\_\_\_\_ Gender: Male Female. Marital Status: S M D W

Address: \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_  
City State Zip code

Allergies: \_\_\_\_\_ Referred by: \_\_\_\_\_

Has any family member been treated by us before? No \_\_\_ Yes \_\_\_ Who: \_\_\_\_\_

**Insurance Information:** Do you have health insurance? \_\_\_ Yes \_\_\_ No

Primary Insurance Company: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policyholder's Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policyholder's Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**May we leave personal medical information on your home answering machine?** \_\_\_ YES \_\_\_ NO

**May we e-mail you personal medical information?** \_\_\_ NO \_\_\_ YES E-mail address \_\_\_\_\_

**May we discuss your medical information with family members?** \_\_\_ YES \_\_\_ NO

If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Please present your insurance card(s) and your photo identification to the receptionist for photocopying.  
You will be asked for an updated Patient Registration Form once a year.

\_\_\_\_\_ / / \_\_\_\_\_

Patient/Parent/Legal Guardian Signature

Date

## The Center For Dermatology Care Financial Policy

Payment is expected at the time of service for any part of the charges that are your responsibility. "Your part" varies depending upon your insurance plan. Please read the information below as it applies to your insurance coverage:

**Private Pay:** Payment for all services provided is due and payable at the time of service. If paying by check, there will be a \$25.00 charge for all checks returned for insufficient funds.

**Cosmetic Services:** All cosmetic consultations require a \$100 deposit, which will be applied to any cosmetic procedure resulting from that consultation. However, if no cosmetic service is rendered, the \$100 deposit will be applied as a consultation fee. All cosmetic appointments require at least 48 hours cancellation notice or the deposit will be forfeited.

**PPO's:** You are expected to pay the co-payment as defined by your plan upon arrival at the office. You are also responsible for payment of any deductible amounts and non-covered services upon exit. You will be billed for any amount due after insurance has paid. Prompt payment is then expected. Also, there may be a separate charge to an outside laboratory that you will be responsible for as well. In the event that you, as the patient, or we, as the physicians, are not aware that a particular service is not covered by your specific plan, you will be responsible for the balance of the charge after we obtain a denial from your insurance carrier.

**Medicare:** You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of your service. You are also responsible for your Medicare annual deductible, as well as any charges for non-Medicare covered or cosmetic services.

**Cancellation Policy:** You agree to accept responsibility for an office visit charge of \$50.00 if you cancel and fail to give 24 hours notice prior to your appointment.

**Worker's Compensation: We DO NOT accept worker's compensation cases.** You are responsible for payment of all services performed at the time of service. If paying by check, there will be a \$25.00 charge for all checks returned for insufficient funds.

**Patient Responsibility:** We frequently experience difficulty with insurance plans in receiving timely payments. If we do not receive payment within 60 days of the date that we bill your insurance, we will transfer the balance to your responsibility and require that you remit payment to Center for Dermatology Care. To prevent this, we suggest that you stay in communication with your insurance company to assure that they are paying for the services we render. Often, insurance companies are more responsive when they are contacted by their policyholders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls would be appreciated. It is the policy of this office to send *only three statements*. The statements are sent at 30 day intervals. If no payment is received on your account during the 90-day period, your account will be turned over to collections without additional notice.

**WE ACCEPT MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE, including Visa, Mastercard, Discover and American Express. We also accept, and can assist you in obtaining, Care Credit – please ask to speak to our billing office if you are interested in this interest free option!** You can indicate your credit card information on your statement or by phone.

I have read, and I understand my financial obligation to The Center for Dermatology Care, and I agree to abide by the terms stated above.

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Signature of Patient or Legal Guardian

Date

Relationship

### AUTHORIZATIONS/ACKNOWLEDGEMENTS

#### **MEDICARE**

I hereby authorize any provider of services to me who files a claim to the Medicare Program, its intermediaries or carrier and to Medigap and any plan to which Medicare crossover to release medical or other information about me that is required for the adjudication of a claim submitted for care provided to me. I also assign payment of any health benefits due me to the party who files an assigned claim to the Medicare program for services provided to me. This authorization is for my lifetime unless revoked in writing by me or my legal guardian or assign.

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Signature of Patient or Legal Guardian

Date

Relationship

#### **NON-MEDICARE**

I hereby authorize any provider of services to me who files a claim to my insurance plan to release medical or other information about me that is required for the adjudication of a claim submitted for care provided to me. I assign payment of any health benefits due me to the party who files an assigned claim to my insurance plan for services provided to me. This authorization is for my lifetime unless revoked in writing by me or my legal guardian or assign.

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Signature of Patient or Legal Guardian

Date

Relationship

**PRIVACY NOTICE:** I have reviewed a copy of the Privacy Rules from The Center for Dermatology Care.

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Signature of Patient or Legal Guardian

Date

Relationship