



FOR OFFICE USE ONLY:

DATE \_\_\_\_\_
CHART NO. \_\_\_\_\_
DOCTOR NO. \_\_\_\_\_

INITIALS \_\_\_\_\_
[ ] NEW PATIENT [ ] UPDATE
ACCT. NO. \_\_\_\_\_
BILL TYPE \_\_\_\_\_

PATIENT INFORMATION

[ ] Mr. [ ] Mrs. [ ] Ms \_\_\_\_\_
LAST FIRST MIDDLE

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Social Security No.: - -

Email Address: \_\_\_\_\_

Birth Date: \_ / \_ / \_ Age: \_\_\_ Marital Status: [ ] MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED Sex: [ ] MALE [ ] FEMALE

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Employer: (company name if self employed) \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Student: [ ] FULL-TIME [ ] PART-TIME School Name: \_\_\_\_\_

INSURANCE INFORMATION

In order to bill your insurance company, this section must be completed in full.

Primary Insurance Carrier: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Social Security #: - -
(if different from above)

Policy Holder's Birth Date: \_ / \_ / \_ Policy Holder's Employer: (if retired, company name) \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Social Security #: - -
(if different from above)

Policy Holder's Birth Date: \_ / \_ / \_ Policy Holder's Employer: (if retired, company name) \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT

Relationship: Self (If self, please leave this section blank.) [ ] Mother [ ] Father [ ] Step Parent [ ] Legal Guardian

[ ] Mr. [ ] Mrs. [ ] Ms \_\_\_\_\_
LAST FIRST MIDDLE

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Social Security No.: - -

Birth Date: \_ / \_ / \_ Employer: (name of company if self employed) \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

PLEASE TURN OVER

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## FINANCIAL POLICY

Since your insurance policy is a contract between you and your insurance company, you are responsible for the cost for services you receive from Dermatology Specialists, Inc. If our office has a contract with your insurance company, we will bill your insurance for you. It is your responsibility to know whether prior authorization is required by your insurance company prior to any office visits or surgery. This requirement may affect your benefits and amounts paid by your insurance. Please inform this office if such authorization is required before services are rendered. You must have your insurance card or you will be required to make a payment at time of service.

It is your responsibility to notify us if your insurance type, primary physician, primary medical group, termination or any other changes have occurred that could affect your insurance coverage for services about to be provided. If we are not informed prior to rendering services, you may be responsible for the cost of the services.

We accept assignment for all Medicare and Tricare patients. Co-payments and deductibles are due and payable at each visit. A \$15.00 processing fee will be added to your account if it is submitted to our collection agency for non-payment or if your check is returned to us by your bank.

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## HMO PLANS

You understand that payment of these services is dependent on prior authorization secured from your primary care physician or health plan and your current eligibility of benefits from your insurance carrier. Should either requirement not be met, you are financially responsible for the service rendered.

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## COSMETIC PROCEDURES

Cosmetic procedures are cash only and cannot be billed to insurance. These procedures include but are not limited to: Botox, Collagen, Restylane, Hair Removal, Facial Veins, Spider Veins, and Skin Tags or benign growths.

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## MISSED APPOINTMENTS

Your appointment time is reserved for you. If you are unable to keep the appointment we request that you call our office at least 24 hours in advance. If you fail to keep your appointment or cancel/reschedule without 24 hours notice, \$30.00 will be charged to your account.

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## RECORD RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Dermatology Specialists, Inc. to release pertinent information regarding my care to other physicians involved in my case and/ or insurance companies holding policies on me. I authorize my insurance company to directly remit payment to Dermatology Specialists, Inc. for medical or surgical services provided and billed by Dermatology Specialists, Inc.

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## ADULT TREATMENT CONSENT

I have read and understand the above Financial Policy.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient Name (Patient Signature)

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## MINOR TREATMENT CONSENT

I have read and understand the above Financial Policy.

I give the doctors and staff at Dermatology Specialists, Inc. permission to treat \_\_\_\_\_ in my absence.

\_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of parent or legal guardian of minor)