PATIENT REGISTRATION FORM

Name _____ Today's Date _____
Last First M.I.

Mailing Address _____ Age _____
Number, Street, Apartment Number

_____ E-mail address _____
City State Zip

Home PH ( ) _____ Work Ph ( ) _____ Cell Ph ( ) _____

Date of Birth _____/_____/_____ SS# _____ Marital Status _____ Gender _____

Employer _____ Retired _____ Full Time Student _____ Part Time Student _____

Person to contact if we are unable to reach you _____ Phone ( ) _____

Referring Doctor _____

May we leave a message on your answering machine? __Y __N

May we leave a message at work for you to call us? __Y __N

May we discuss your medical condition with any other person? __Y __N

If yes, whom? _____ Relationship _____

Would you like to occasionally receive information about skin care procedures and products that we offer? __Y __N

How did you hear about our practice? _____

Insurance Policy Holder_____ Policy Holder's Birthdate _____/_____/_____

Policy Holder's SS# _____ Policy Holder's Employer _____

Policy Holder's Address (if different than patient's)

_____
Number Street City State Zip

Patient's Relationship to Policy Holder _____ Phone ( ) _____

If patient is a minor, please enter responsible party information. (NOTE: **We do not bill absent parents; the adult presenting the minor for care is the financial responsible party.)**

Name _____ SS# _____
Last First M.I.

Address _____
Number, Street, Apartment Number City State Zip

Home PH ( ) _____ Work Ph ( ) _____ Cell Ph ( ) _____

Signature of patient or representative _____ Date _____

ASSIGNMENT OF BENEFITS

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Advanced Dermatology and Skin Cancer Center. I authorize this office to provide to my insurance company, any information necessary to process claims for services rendered to me.

_____ _____

Signature as it appears on your insurance card **Date**

MEDICARE

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 need 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.

_____ _____

Signature as it appears on your Medicare card **Date**

MEDIGAP

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 my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on your MEDIGAP card **Date**

Y N Do you or your spouse work in a company which has more than 20 Employee's and have coverage through insurance at that job?

Y N Are you covered by any other insurance that makes Medicare secondary?

Advanced Dermatology & Skin Cancer Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing Advanced Dermatology & Skin Cancer Center for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our notice.

_____

Signature of Patient (or Legal Representative)

_____

Date

_____ _____ _____

Signature of Staff Member **Title** **Date**

Comments:

PATIENT FINANCIAL POLICY

Advanced Dermatology and Skin Cancer Center

Melody L. Stone, M.D., FAAD

Amy Horner, P.A.-CS Sileen Dowis, P.A.-C

This office has contracts with Medicare and with many managed care plans. Please check with our reception staff to determine whether your plan is one of these.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible (any deductibles, copays, percentages, or non-covered services) is required at the time of service.

If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask someone from the business office who will be happy to discuss the cost with you.

For your convenience in paying, this office accepts MasterCard, Visa, Discover, and American Express in addition to cash and checks. In an effort to keep patient cost down, we are not able to extend credit. However, we do accept Care Credit. Please ask for someone from the business office or go to Carecredit.com for more information.

If you must cancel an appointment, please give us a 24 hour notice so we may schedule another patient who has been waiting. Patients who continuously do not keep their appointments, and who do not call to cancel, may be released from the practice.

I certify that I have read the financial policy of Advanced Dermatology and Skin Cancer Center and agree to abide by that policy.

Signature_____ **Date**_____