PATIENT INFORMATION

LAST NAME: _____ FIRST: _____ M.I.: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

SOC. SEC. #: _____ DRIVER'S LIC. #: _____ MARITAL STATUS: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Referred by: _____

EMERGENCY CONTACT INFORMATION

LAST NAME: _____ FIRST: _____ PHONE #: ( ) _____

_____

RESPONSIBLE PARTY

(PLEASE COMPLETE IF PATIENT IS A MINOR OR SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT)

LAST NAME: _____ FIRST: _____ M.I.: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____ SS#: _____

INSURANCE INFORMATION

PRIMARY INS. CO.: _____ POLICY NO.: _____

NAME OF POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INS. CO.: _____ POLICY NO.: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Affiliates in Dermatology to release my medical and/or financial information to the following people. (Please List)

☐ _____

☐ NONE _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of Notice of Privacy Practices.

☐ I ACCEPTED MY COPY ☐ I DECLINED MY COPY

PLEASE TURN OVER

FINANCIAL RESPONSIBILITY WAIVER

PATIENTS WITH INSURANCE: Although we will bill your insurance company or Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan or Medical Group, we will contact you for assistance. Should your health plan or Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement. We are under legal and contractual obligation to collect all balances, copays and insurances at the time service is rendered.

DUAL COVERAGE: AFFILIATES IN DERMATOLOGY abides by the California State insurance laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary and tertiary health plans.

PATIENTS WITHOUT INSURANCE: Our fees cannot always be determined in advance, since they depend on services rendered. You will, therefore, be quoted a deposit amount, which must be paid at the time of visit. Any charge over the deposit amount will be billed to you and will be due in full within thirty (30) days from the date of your billing statement.

FAILED APPOINTMENTS: You will be charged $25.00 if you do not cancel your appointment 24 hours in advance of your scheduled appointment.

SPECIALTY LETTERS/FORMS: $25 and up. The exact fee will depend on the complexity of a letter you request.

I have read and understand the above policies and I agree to comply with them. I attest that all information given to us is true and accurate to the best of my knowledge.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

PATIENT SIGNATURE_____ Date _____