

Dermatology & Advanced Skin Care
6021 University Blvd., Suite 390 Ellicott City, MD 21043
410-203-0607

Patient Information

Patient's Name (Last, First, Middle)			Date
			Home Phone Number
Address			Work Phone Number/Extension
City	State	Zip	Cell Phone Number
Male <input type="checkbox"/> Female <input type="checkbox"/>	Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred phone number to contact you: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-mail Address			Date of Birth / /
Employer/ School Name			Occupation
Responsible Party			Responsible Party Phone Number
Billing Address If Different Than Above			
Were you referred by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, physician's LAST NAME, FIRST NAME:	
Person to notify in an emergency		Relationship	Phone Number

Insurance Information

Primary Insurance Carrier	
Group Name or Number	ID #
Address of Insurance Company	City /State/ Zip
Primary Policyholder's Name (Last, First, Middle Initial)	Policy Holder's Date of Birth / /
Policy Holder's Employer	Is insurance through work? Yes <input type="checkbox"/> No <input type="checkbox"/>
What is your relationship to the policyholder? Circle One: I am the: Holder <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/>	Is a Referral Required? Yes <input type="checkbox"/> No <input type="checkbox"/>

Secondary Insurance Carrier	
Group Name or Number	ID #
Address of Insurance Company	City /State/ Zip
Primary Policyholder's Name (Last, First, Middle Initial)	Policy Holder's Date of Birth / /
Policy Holder's Employer	Is insurance through work? Yes <input type="checkbox"/> No <input type="checkbox"/>
What is your relationship to the policyholder? Circle One: I am the: Holder <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/>	Is a Referral Required? Yes <input type="checkbox"/> No <input type="checkbox"/>

Patient Consent for Use and Disclosure of Protected Health Information

I consent for Dermatology & Advanced Skin Care to disclose health information about me to carry out treatment, payment, and healthcare operations and to contact me regarding such matters as appointment reminders, insurance, and issues pertaining to clinical care. I authorize Dermatology & Advanced Skin Care to disclose appointment, medical, and financial information to:

Person authorized to receive your medical information (e.g. family member)

This authorization may be revoked in writing at any time.

Signature of Patient or Guardian

Date

Cancellation Policy for Appointments

If you are unable to keep your appointment, kindly provide 24 hours notice to avoid being assessed a cancellation fee. **Surgical appointments** require 48 hours notice. The cancellation fee ranges from **\$25 to \$100** depending on the nature of the appointment. Appointments can be cancelled by calling our office. Messages can be left 24-hour a day. Please sign below indicating that you are aware of this policy.

Signature of Patient or Guardian

Date

Financial Policies

Concerning Insurance and Assignment of Benefits

I authorize this physician to apply for benefits on my behalf for covered services rendered. I certify the information I have reported with regard to my insurance is correct. If the information is found to be incorrect, I understand that I will be responsible for providing correct information or will be responsible for the incurred costs. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. A copy of this authorization may be used in place of the original. The authorization may be revoked by me or my insurance carrier at any time in writing.

I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Dermatology & Advanced Skin Care for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company, including but not limited to termination of coverage at time of visit, a non-covered benefit per my insurance plan, a cosmetic procedure, or lack of referral from my primary care physician. I also understand I am responsible for any collection agency fees (30-50% of the account balance) occurred from an overdue account.

Signature of Patient or Guardian

Date

For Medicare Patients Only

I understand that in certain circumstances under Medicare law, Medicare may decide that services are not medically necessary or are cosmetic in nature. Since Medicare will deny payment for these services, I agree to be personally responsible for payment of these charges.

Signature of Patient or Guardian

Date