Patient: ____ Date: ____________
Last Name First Name Middle Initial

Birth Date *(include year)*:_______________Soc. Sec. #:___________________ ☐Male ☐ Female

Mailing: ______________________________ Home Phone ( ) _______________
Address Work Phone ( )_______________
__________________________________ Cell Phone ( ) _______________
City State Zip code

Patient's Employer: ____

Email Address: ____
Please check here if you ***DO NOT*** *want to receive promotional or informational emails regarding our services* ☐

Primary Insurance: ____

Secondary Insurance: ____
Please provide us with a copy of your insurance card and driver's license to verify your signature and date of birth.

Person Responsible for Bill: (*Insurance Guarantor*)

Relationship to Patient: ☐ Self (*please skip this section and go to insurance information*)

☐ Spouse ☐Child ☐Dependent

Name: ____
Last Name First Name Middle Initial
Address: __________________________________ Home Phone ( ) _______________
__________________________________ Work Phone ( ) _______________
City State Zip

Emergency Contact Information: In case of an emergency, local friend or relative to be notified (not living at same address):

Name: _________________________ Relationship to Patient: ______________________

Home Phone: ( ) _________________ Work Phone:( )________________________

Who may we thank for referring you?

____
Name (first/last) - if a provider please include clinic name or phone number

I certify the above information is correct to the best of my knowledge.

_______________________________ _______________________________
Name of Patient or Responsible party *Signature of Patient or Responsible Party*

____
Date of signature

DERMATOLOGY ASSOCIATES FINANCIAL AGREEMENT

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office. We ask that you notify us of any changes to your insurance coverage or carrier(s) and for you to bring your insurance card with you at each visit.

Due to the overwhelming number of insurance plans, it is impossible for our front desk staff to guarantee coverage by any individual plan. It is your responsibility to verify that we are a member of your PPO or HMO network before presenting to our office for treatment. It is also your responsibility to know if you need a referral from your Primary Care Physician (PCP) before seeing a dermatologist.

1. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for services rendered. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 30 days after receipt of the statement.
   You will be responsible at the time of service for payment of:
   - The annual deductibles
   - Co-payments
   - Charges for non-covered or cosmetic services

   **In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.*

2. We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:
   - The annual deductibles
   - Co-payments
   - Charges for non-covered or cosmetic services

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do NOT have a contractual relationship (out of network), please note the following:
   - We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 30 days after receipt of the statement.
   - Any amount not paid by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you and is due and payable 30 days after receipt of the statement.

4. Lab tests and/or pathology specimens sent to outside laboratories will be billed <u>separately</u> from Dermatology Associates charges. The laboratory service will bill your insurance for their services.

5. In the event your account is turned over to a collection agency due to non-payment, you understand and agree that you may be responsible for any collection fees including attorney fees and court costs.

6. If you need to change your appointment, please do so within 24 hours of the appointment time to avoid missed appointment charges. The charge is $75.00 for any missed office appointment and $100 for any missed procedure.

I certify that I have read and understand the "Financial Polices" and agree to all terms and conditions as stated above. I understand that it is my sole responsibility to verify insurance coverage and I am ultimately responsible for payment in full for any outstanding balances.

Patient Printed Name: ______________________________________ Date: ______________________

Patient Signature: ____