Patient name: _____

Responsible party's name (for minors):_____
_____

Address:_____

City: _____State:_____Zip: _____

Numbers we may use to contact you:

Home phone: _____cell: _____

Sex: M F Age:___ Birthdate: _____

Employer Name: _____

Work phone Number: _____

Marital status: single married divorced

Spouse name: _____

Referring doctor name: _____

Primary Insurance Information:

Insurance name: _____

Insurance holder name: _____

Insurance holder's birthdate: _____

Identification number: _____

Group number: _____

Relationship to patient:_____

Secondary Insurance Information:

Insurance name: _____

Insurance holder name: _____

Insurance holder's birthdate: _____

Identification number: _____

Group number: _____

Relationship to patient: _____

Emergency contact: _____
Emergency Phone: _____
Name of pharmacy:
_____
Pharmacy phone number:
_____
Primary Care Doctor:
_____
Do you have another address? _____

Financial Policy: Payment in full is required at the time services are rendered, unless you are currently enrolled and eligible under one of the
Insurance plans that lists this office as a participating network provider. Please check with your insurance company to verify this information. Please understand health plans have different copays, deductibles and rules and regulations regarding allowed visits for certain services. If our office participates with your health plan, we will honor the applicable fee schedules and discounts. You will be responsible for your co-payments, any co-insurances and applicable deductible amounts.
If our office does not participate with your health plan, payment in full is due at the time you exit our office for the services rendered to you. Our office accepts payment by: cash, check, money order, debit card, Visa, MasterCard, or Discover. There will be a $25.00 fee assessed on all returned checks. As a courtesy to you, a claim is submitted to your insurance plan on your behalf. Once your insurance company considers your claim, if you still owe a balance after their decision, a statement will be sent to you. Our billing office will send three statements and one delinquency notice to you. If you neglect to pay your bill, or you refuse to make payment arrangements, Your account will be forwarded to a collection agency.

I acknowledge that it is the policy of this office that payment is required at the time of service. An insurance claim submission on my behalf is a courtesy extended to me, or the party I represent, unless mandated by the health plan. I am financially responsible for all services not covered by my health plan.

_____
Patient signature Date

Patient Payment Authorization:
I hereby authorize my insurance company to send all payments for medical services rendered to me (or my dependents) directly to: Dermatology Associates of Central Florida. With my signature, I confirm the above demographic and insurance information is true and correct, and for any future services this authorization

applies to. If the information is found to be inaccurate, I agree to be personally responsible for payment in full for the services provided. I further authorize the release of any information (including medical information) to my insurance company in order to determine the insurance benefits for which I may be entitled to.

_____

Patient signature Date

This section- for Medicare patients only

I authorize the release of any medical information about me needed to process any claim or related procedure to the Social Security Administration and the Centers for Medicare and Medicaid Services, as well as its contractors and administrators. 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.

_____

Patient signature Date

Medigap/Secondary Insurance Companies:

I request authorized Medigap benefit payments to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits payable for related services.

_____

Patient signature

Laboratory/Biopsy Services: We provide the professional services portions for these procedures. If a specimen is sent to an outside source to confirm a diagnosis, you will be billed separately by the laboratory that provides the service.

_____ _____/____/_____

Patient Signature Date

Do we have your Permission to:

Leave a message at your home number: Y N
Leave a message at your work number? Y N
Discuss patient's treatment with a family member? Y N

If Yes, Whom? _____

RELEASE OF MEDICAL INFORMATION: Our HIPAA Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. The Notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this consent, you specifically authorize our use and disclosure of protected health information about you for treatment, payment or health care operations, and as otherwise explained in the Notice of Privacy Practices. You specifically authorize the use and release of all of your health care information including, but not limited to mental health, HIV/AIDS, genetic testing, venereal disease, substance abuse, and tuberculosis information for treatment, payment, health care operations, and as otherwise permitted by law. Your information may be exchanged electronically.

_____

Patient Signature (or Representative)

_____/_____/_____ _____

Date Relationship if not patient

Receipt of Notice of Privacy Practices Written Acknowledgement:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Dermatology Associates of Central Florida. Copy is available upon request.

Patient Signature (or representative)

___/____/_____ _____

Date Relationship if not patient

Office Use Only:

Staff Signature

_____

Date Printed Name of Staff