SKIN CANCER SPECIALISTS, P.C.

Today's Date:

Prefix (circle one) **Mr. Mrs. Miss Ms. Dr. Rev.** ____________________ **Preferred Name:** ____________________

Patient's Name: ____
First Middle Last

Address ____

SS# __________ **Birthdate** __________ **Age:** __________ **Sex:** ❒ **Female** ❒ **Male**

Marital Status ❒ **Single** ❒ **Married to:** __________ ❒ **Other:** __________

Home Phone __________ **Cell Phone** __________ **Work Phone** __________

Preferred Contact: ❒**Home** ❒ **Work** ❒**Cell** ❒ **Email** ❒**Text** **E-mail** __________

Any restrictions for contacting you? ❒ **No** ❒ **Yes** **If yes, please describe** __________

Emergency Contact __________ **Relationship to Patient** __________

Home Phone __________ **Work Phone** __________ **Cell Phone** __________

Patient's Employment ❒**Full-Time** ❒**Part-Time** ❒**Student** ❒**Retired**

Patient's Employer __________ **Occupation** __________

Spouse's Employer __________ **Occupation** __________

Patient's Race: __________ **Patient's Ethnicity:** __________ **Patient's Language:** __________

How did you hear about us?

Friend (Name) __________ **Insurance/Internet/Other** __________

Referring Dr.: __________ **Primary Care Dr.:** __________

Primary Ins. __________ **Address:** __________

Insured: Name __________ **DOB** __________ **SS#** __________

Relationship to the insured? ❒**Self** ❒**Child** ❒**Spouse** ❒**Other** __________

Policy # __________ **Group #** __________ **Deductible:** __________

Copay? ❒ **No** ❒ **Yes** __________

Secondary Ins. __________ **Address:** __________

Insured: Name __________ **DOB** __________ **SS#** __________

Relationship to the insured? ❒**Self** ❒**Child** ❒**Spouse** ❒**Other**

Policy # __________ **Group #** __________ **Deductible:** __________

Pharmacy Name __________ **Pharmacy Phone #** __________

Pharmacy Location __________

Allergies __________ **Medications** __________

Date & Sign __________

PRIVACY PRACTICES NOTICE AND WRITTEN ACKNOWLEDGEMENT FORM

I have been offered a copy of the Skin Cancer Specialists, P.C. Notice of Privacy Practices.

Signature of Patient/Guardian:**________________________________** ***Date:*****______________**

Permission is given to leave medical information in the specified manner and to the specified person(s) listed below.

_____ You may leave messages on my home answering machine

_____ You may call my work number

_____ You may leave messages on my work voicemail

_____ You may leave messages on my cell phone voicemail

_____ You may share information to no one but myself

_____ You may share medical and account information with my spouse _________________________
[NAME]

_____ You may share medical and account information with my children _________________________
[NAME(S)]

_____ You may share medical and account information with ________________________________
[NAME]

AUTHORIZATION OF PAYMENT AND RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to Skin Cancer Specialists, P.C. and authorize release of medical information to determine payable benefits for services rendered.

Signature of Patient/Guardian:**__________________________________** ***Date:*****_____________**

Skin Cancer Specialists, P.C.
Financial Policy

The following is a statement of our financial policy which we require you to read and sign. For your convenience, we accept checks and most credit cards.

INSURANCE

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is therefore necessary for us to have a current copy of your insurance card for accurate billing. Insurance benefits will be verified by our office, but it is recommended that you educate yourself about your individual benefits by contacting your insurance company before being seen. It is required that we hold you responsible for your portion of the charges, including copays and deductibles, at the time of service. If your insurance company has not paid a claim within 60 days, you may receive notification in the mail requesting your assistance in determining if there is a problem, or if additional information is required in processing the claim.

NON-COVERED SERVICES

There are a number of services we provide that are typically considered "cosmetic" by your insurance company. For example, removal of some benign growths such as skin tags are not routinely covered by health insurance plans. Other services, such as Botox, fillers, chemical peels, and laser, are also considered not medically necessary. Full payment for all non-covered services must be made at the time of your visit.

REFERRALS

Since we are a dermatology office in the state of Georgia, referrals are not usually required. If your insurance company does require a referral, it is solely your responsibility to obtain a current referral for office visits. You must bring the referral to our office on the day of your appointment.

LABS

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, you must inform your nurse. Our office sends a copy of your insurance card with the specimen to an outside facility. These charges are billed directly from the laboratory itself and are separate from our office charges. You will receive an explanation of benefits (EOB) from your insurance carrier.

NO SHOWS

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is your responsibility to arrive for your appointment on time. Cancellations must be received greater than 24 hours in advance. Any patient who no-shows or cancels his or her appointment with less than a 24 hour notice may be charged a $100 refundable deposit in order to schedule any future appointments. This charge cannot be billed to your insurance company. This charge will be held until the claim for services rendered is paid in full by your insurance company, and any amount left over will be refunded to you. The $100 will not be refunded for no-shows or cancellations within 24 hours.

Thank you for your understanding of our policies. Please let us know if you have any questions or concerns.
I have read the above financial policy, and I understand and agree to its terms.

______________________________ ____________

Signature of patient or responsible party Date