Center for Skin Surgery & Dermatology, PLLC

Patient Information: Please complete all sections and bring to your appointment Chart #_____

Last Name: _____ First Name: _____ MI: ____ ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

Home Address: _____

City: _____ State: _____ Zip Code: _____-_____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Email: _____ Sex: M F Birthdate: _____

Circle the best way to contact you: home cell work

Place of Employment: _____ Occupation: _____

Emergency Contact: _____ Relationship _____ Phone# _____

Primary Care Doctor: _____ City: _____ State _____

Referring Doctor: _____ City: _____ State _____

Primary Insurance Name: _____ Subscriber Name: _____

Relation to Patient: Self Spouse Dependent Birthdate: _____

Secondary Insurance Name: _____ Subscriber Name: _____

Relation to Patient: Self Spouse Dependent Birthdate: _____

Notice of Privacy Practices: (If the patient is a minor a separate form is required)

A Notice of Privacy Practices has been provided to me from CSSD. **Signature** _____
(A copy is located at our front desk for your convenience)

Do you give our office permission to discuss your medical information with family member? ____Yes _____No

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone # _____

Authorization of Assignment and Release:

I authorize payment of Medicare and/or other insurance benefits be made on my behalf to Center for Skin Surgery & Dermatology, PLLC for any services furnished me by Center for Skin Surgery & Dermatology PLLC. I authorize release of any information needed to determine these benefits or benefits payable for related services.

_____ _____
Your Signature Today's Date

Financial Agreement:

I certify that the insurance information I have provided is accurate. Insurance Claim submission is provided as a courtesy to me. If my insurance requires a referral and I do not obtain one, I am responsible for payment in full. I will be responsible for all co-payments, deductibles and balances not covered by my health insurance. **I agree to pay any co-payments, deductible amounts and past balances at the time of service.** Payments can be made in the form of cash, check or charge card (Visa/Mastercard). I understand that statement balances are due within 30 days of receipt. **In the event of default:** After 30 days an 18% per annum finance charge may be added to my outstanding account. After 75 days my account will be processed for collections. I agree to pay, in addition to the amount that is outstanding, any collection costs and attorney fees associated with collecting the debt. I also understand there will be a $30.00 fee for each returned or NSF checks.
I understand that appointments not cancelled within 24 hours prior to scheduled time will be subject to a $75.00 fee.

_____ _____
Your Signature Today's Date

Please give your Insurance card to the receptionist to copy.