Dermatology Associates, P.A.

INSURANCE INFORMATION

If under 18, Name of person responsible for bill ______________________________________ Relationship to patient___________

Address of responsible party ____ Phone (___) _________________

Primary Insurance:

Name of Insurance Co:_____________________________________

Policy Holder's Name: _____________________________________

Policy Holder's SS#: _____________________________________

Policy Holder's DOB: _____________________________________

Policy Holder's Employer: _____________________________________

Relationship to Patient: _____________________________________

Secondary Insurance:

Name of Insurance Co: _________________________

Policy Holder's Name: _________________________

Policy Holder's SS#: _________________________

Policy Holder's DOB: _________________________

Policy Holder's Employer: _________________________

Relationship to Patient: _________________________

I authorize the release of any medical or other information necessary to process Insurance claims. Any authorization needed for my insurance is my responsibility at time of service and I will be responsible for payment if authorization is not obtained. I also request payment of insurance government benefits to myself or the party who accepts assignment. My printed name below serves as my electronic signature.

Print Name: ____ Date: ______________________________________

****** PLEASE SHOW INSURANCE CARDS ******

Please sign below after reading our Privacy Practices listed on the website or upon arrival of your appointment.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. My printed name below serves as my electronic signature.

Print Name: ____ Date: ______________________

Please list any family members or patient representatives you would like to share your Protected Medical Information: Let us know if you will allow us to leave messages on your home answering machine regarding your care/ pathology

Check one: Yes it is okay to leave a message No, do not leave messages

PATHOLOGY BILLING POLICY ACKNOWLEDGEMENT

I have read and understand the Pathology Billing Policy. My printed name below serves as electronic signature:

Print Name: ____ Date: ___________________________________