Patient Information

Today's Date: _____/_____/_____

Name: _____
Last First M.I.

Date of Birth: _____/_____/_____ Age: _____ Sex: ❑ Male ❑ Female Soc. Security #:_____

Address:

Mailing Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

To confirm return appointments, may we email or text you? ❑ Yes ❑ No Email: _____

With my consent Greenwood Dermatology may text, call, leave a message or mail to my home any items that assist the practice in carrying out treatment payment, and healthcare operations.

Greenwood Dermatology may call and/or text appointment reminders ❑ Yes ❑ No

Greenwood Dermatology may text or leave a message with any medical information on my voicemail ❑ Yes ❑ No

Signature:_____

Place of employment:_____ Phone: ( ) _____

Spouses place of employment:_____ Phone: ( ) _____

Emergency Contact Information

In case of Emergency, who should be notified? _____ Phone: ( ) _____

Relationship to patient: _____

Parent, Spouse or Responsible Party ***(if different from patient)***

Name: _____ Date of Birth: _____/_____/_____
Last First M.I.

Address: _____
City State Zip Code

Home Phone: ( ) _____ Work Phone: ( ) _____

Physician Information:

Family Physician_____Address:_____

Were you referred by a physician? _____ If yes, who is the referring physician:_____

Address or phone number of referring physician:_____

Insurance Information:

Primary Insurance Carrier: _____ Policyholder's Name: _____

SSN# _____ Birthdate _____Relationship to Patient:_____

Preferred Pharmacy:_____ Phone: ( ) _____

Specialty Pharmacy:_____ Phone: ( ) _____

Secondary Insurance Carrier: _____ Policyholder's Name: _____

SSN# _____ Birthdate _____Relationship to Patient:_____

Please sign so we may have your insurance authorization on file

I authorize any holder of medical and/or other information about me to be released to the above insurance company(s), and any information needed for this or a related insurance claim. I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I will be billed and I am responsible for any amount that is not covered by my insurance.

Date:_____/_____/_____ **Signature: _____**

Please present your insurance card(s) and a photo ID to the receptionist.

(Over)

Payment Policy:

The doctor appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. The patient or legal guardian is responsible for all fees incurred for office medical services regardless of insurance coverage. This includes any amount the insurance does not cover for office visits and in the unlikely event of complications from treatment, the patient is responsible for fees charged by other physicians or hospitals. Any amount that insurance does not pay will be billed directly to you. Any co-payments that you are liable for with your policy, as well as any medications, charges for noncovered services, products you may purchase at the office, and cosmetic services are due at the time of the visit.

Electronic recording is prohibited within the office.

The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

If we receive payment from the primary insurance, we will file a claim with your secondary. If we do not receive payment from your primary carrier, you will be billed for the entire amount.

It is ultimately the patient's responsibility to verify that the physician is in your network, and to obtain any referrals your insurance may require.

Payment is expected when services are rendered. Delinquent accounts are subject to a 10% late fee.

If insurance does not pay your claim within 90 days, you will be responsible for the amount in full. It is your responsibility to make sure that these claims are paid in a timely manner.

We are not Medicaid providers. You will be financially responsible for any balance that your primary insurance does not cover.

I understand that should my account become past due it may be placed with a collection agency. **If it is, I am aware that I am responsible for all collection agency fees (33 1/3%) of my account balance), attorney fees and court cost.**

No Show / Late Cancellation: In order to provide timely care for all of our patients, we have a no show / late cancellation fee. A twenty-four hour cancellation of your appointment must be given to avoid being assessed a $50.00 charge for a missed appointment. If you miss a scheduled surgery appointment there will be a $100.00 fee. These fees are not covered by your insurance.

There will be a $25.00 charge for any returned checks.

Print Name: _____

Signature: _____ Date:_____/_____/_____