ASSOCIATED Skin Care Specialists, P.A.

PATIENT INFORMATION FORM

OFFICE USE ONLY

Today's Date: _____ **Insurance** **Annual** **New** **Account #** _____ **Recep. Int.** _____

Patient Information

Patient Name: _____ **Date of Birth:** _____ Sex: ☐ M ☐ F
Last Legal First Middle

Social Security Number: ___ - ___ - ____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other

Address: _____ _____ _____
Street City State Zip

Employer: _____ **Home Phone:** ( ) _____
Name and City of Firm

Work Related: ☐ Yes ☐ No Are calls allowed at work? ☐ Yes ☐ No **Work Phone:** ( ) _____

Emergency Contact Person: _____ Relationship: _____

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

Primary Care Physician: _____ Phone: ( ) _____

If patient is a minor or on Worker's Compensation, person to whom bill will be sent

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F
Last Legal First Middle

Social Security Number: ___ - ___ - ____

Address: _____
Street City State Zip

Employer: _____ Work Phone: ( ) _____
Name and City of Firm

Address: _____ Home Phone: ( ) _____

Relationship to Patient: _____ Are calls allowed at work? ☐ Yes ☐ No

My insurance (circle one) **does / does not** require a referral. _____ initials

Primary Insurance

Primary Insurance Name: _____

Primary Insurance Address: _____

City: _____ State: _____ Zip: _____

Policy No: _____ Group No: _____

Policyholder: _____ **Date of Birth:** _____

Relationship to Patient: _____

Secondary Insurance

Secondary Insurance Name: _____

Secondary Insurance Address: _____

City: _____ State: _____ Zip: _____

Policy No: _____ Group No: _____

Policyholder: _____ **Date of Birth:** _____

Relationship to Patient: _____

IN ORDER TO CONTROL THE COST OF BILLINGS, YOUR PORTION OF THE CHARGES ARE TO BE PAID AT THE TIME OF SERVICE. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I request that payment of authorized insurance benefits, including Medicare, be made to **Associated Skin Care Specialists, P.A.** for any services furnished to me by any provider employed or contracted by this clinic.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, any insurance company, or any others responsible for payment information needed to process claims, determine benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse, and to my minor children. I/we agree to pay all charges not covered by insurance.

Associated Skin Care Specialists, P.A. reserves the right to refuse service if an account is delinquent or has been assigned to an outside agency for collections.

I authorize **Associated Skin Care Specialists, P.A.** to contact me regarding appointments scheduled with **Associated Skin Care Specialists, P.A.** doctors.

Research Participant: This is to inform you, at times, the ***Minnesota Clinical Study Center***, a division of **Associated Skin Care Specialists, P.A.** will send notices of upcoming studies. If you do not wish to be notified, please inform the front desk.

Signature: _____ **Date:** _____
Responsible Party: _____ Date: _____