The Center for Dermatology, P.C.
Patient Information

Name: _____ Birthdate: _____
Last First Middle Preferred name

Mailing Address: _____
City State Zip

Phone: Home (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

SS#: _____ Gender: Male Female Marital Status: Single Married Divorced Widowed

Race: _____ Ethnicity: Hispanic Non-Hispanic Other Email address: _____

Parent or Responsible Party (if different from patient)

Name _____ Birthdate:_____ Relationship to patient:_____

Phone: Home: (_____)_____ -_____ Work (_____) _____-_____ Cell (_____) _____-_____

Mailing Address: _____
City State Zip

Insurance information

Primary Insurance Name: _____

Policy Holder's Name: _____ SS#: _____ Birthdate: _____

Contract #:_____ Group#: _____ Relationship to patient: _____

Secondary Insurance Name: _____

Policy Holder's Name: _____ SS#:_____ Birthdate: _____

Contract #:_____ Group #: _____ Relationship to patient: _____

Emergency Contact – someone not living at your same address

Name: _____ Phone #: _____ Relationship: _____

Whom may we thank for referring you to our practice? _____

All of the above information is correct to the best of my knowledge and I agree to notify this office in a timely manner of any changes.

Patient or Responsible Party Signature: _____ Date: _____

The Center for Dermatology, P.C.
Consent Form

Patient's Name: _____ Birthdate: _____

Please initial each item below. All items must be initialed before you can be seen.

_____ I hereby authorize The Center for Dermatology, P.C. to administer treatment and perform necessary procedures in diagnosing and/or treating my condition.

_____ I understand that **if I am uninsured or have an insurance that is not accepted** at the practice that I will be responsible for payment IN FULL at the time of service.

_____ I understand that **insurance copays, deductibles, co-insurance and charges not filed with insurance are due at the time of service**. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all costs for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State of Alabama and any other state.

_____ I understand that **I will be responsible for ANY charges that are not paid by my insurance company**. Not all services are covered and I understand that it is my responsibility to know the limits of my coverage and to pay any fees that my insurance company denies. As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file your own claims.

_____ I understand that most procedures may fall under major medical, therefore I will be responsible for paying the deductible amount in a timely manner. Procedures include treatment of skin lesions (including warts, molluscum, moles, tags, precancers, skin cancers) by any method (including freezing, biopsy and in-office application of medication) and acne peels.

_____ I authorize the release of medical information to my primary care or referring physician, to consultants, if needed and as necessary to process insurance claims (including Medicare), insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. This assignment will remain in effect until revoked by me in writing. This assignment is considered to be as valid as an original.

_____ I understand it is my responsibility to notify the provider of any changes in my insurance company. I will be responsible for any claims denied due to incorrect insurance information. I understand that I am responsible for obtaining any referrals required by my insurance prior to my appointment. If I do not have a required referral, I may elect to reschedule my appointment or pay in full at the time of service.

_____ I authorize the practice to call my home or other designated locations and leave messages in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

_____ I am aware that the practice has a **Notice of Privacy Practices** that contains a section on Patient Rights. I have been given the opportunity to review this Notice and a copy will be provided upon my request.

Patient or Responsible Party Signature: _____ **Date**: _____