

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Associates in Dermatology, Inc.*

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sex: M F Marital Status: S M W D Preferred Language: English / Spanish / Other

Race: Asian / Black / Hispanic / White / Other Ethnicity: Non-Hispanic / Hispanic / Other

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Guarantor: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Contact #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information**

Primary Insurance Carrier; \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Sex: M F

Policy Holder's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Sex: M F

Policy Holder's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Additional Contact Information (someone NOT living in the same residence)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

*Associates in Dermatology, Inc.*

I request that payment of authorized insurance benefits be made either to me or on my behalf to Associates in Dermatology, Inc. (AID), for any services furnished to me by the listed provider/employee of AID. I authorize any holder of medical information about me to release to any federal or commercial health insurance organizations any information needed to determine these benefits or the benefits payable for related services.

I understand by signing this form that I am requesting that insurance payments for services rendered to me be made directly to AID and that I am authorizing the release of my medical information to pay applicable claim(s). If "Other Health Information" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown. With certain insurers, the patient may be responsible only for the deductible, co-payment, co-insurance, or non-covered services. Co-insurance and the deductible are based upon the charge determination of the individual carrier.

I understand that if my insurance company requires a referral form for treatment that it is my responsibility to obtain this referral prior to my appointment. If the required referral form is not received, I understand that my appointment may need to be rescheduled until such time as the referral can be obtained.

The undersigned states that they have read the materials provided or had them read to them, and they understand payment is due when services are rendered. Upon default in making payment, the undersigned agrees to pay all reasonable legal fees and costs of collection to the extent permitted by Virginia law. Each guarantor waives presentation of payment, notice of non-payment, protest and notice of protest and agrees to all extensions, renewals, or release, discharge or exchange of any party or collateral without notice. This note shall take effect as a sealed instrument and be enforced in accordance with the laws of the Commonwealth of Virginia. This agreement shall be binding upon and inure to the benefit of the parties, their successors, heirs, assigns and personal representatives.

I have read, understand and agree to this financial policy. I understand that any charges that are not covered by my insurance company, as well as applicable co-payments and deductibles, are my personal responsibility.

I acknowledge that I have been given the opportunity to receive/read a copy of Associates in Dermatology, Inc.'s Notice of Privacy Practices.

I authorize Associates in Dermatology, Inc. to leave a detail message on my answering machine. YES NO

I authorize Associates in Dermatology, Inc. to discuss my medical information with the following people:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

May Discuss: Medical Care / Billing Information / Both

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

May Discuss: Medical Care / Billing Information / Both

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name