COASTAL
SKIN SURGERY & DERMATOLOGY

(PLEASE PRINT) **PATIENT INFORMATION**

LAST NAME ______________________ FIRST ______________________ MIDDLE ________

CELL PHONE ______________ ALT/HOME PHONE______________ EMAIL ______________________

ADDRESS ____ APT # __________

CITY______________________________________ STATE __________ ZIP CODE __________

EMPLOYER/SCHOOL ______________________________________ WORK PHONE______________

DATE OF BIRTH ______________ SEX _____ MARITAL STATUS______SSN______________________

RACE ______ ETHNICITY: __________ LANGUAGE: __________HOW WERE YOU REFERRED? ______________

EMERGENCY CONTACT & NUMBER ______________________________ PHYSICIAN ______________

RESPONSIBLE PARTY INFORMATION

NAME______________________________ RELATIONSHIP __________DATE OF BIRTH__________

SSN ______________ HOME PHONE ______________ WORK PHONE ______________

ADDRESS____

IF MINOR: MOTHER ______________ FATHER ______________ LEGAL GUARDIAN______________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ______________________________Group number __________

Policy Number______________ Subscriber ______________ Subscriber DOB __________

Relation to patient __________ Address (if diff than patient) ______________________

SECONDARY INSURANCE COMPANY ______________________________Group number __________

Policy number ______________ Subscriber ______________ Subscriber DOB __________

Relation to patient __________ Address (if diff than patient) ______________________

RELEASE OF MEDICAL INFORMATION

I, by my signature on the back of this form, as the patient OR his/her representative, do hereby authorize **Coastal Skin Surgery and Dermatology**, to release to my insurance company(s) or other appropriate agency(s) that information which is necessary to validate this claim. **Coastal Skin Surgery and Dermatology**, is also hereby authorized to release to my physician(s), whether as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes. I hereby authorize **Coastal Skin Surgery and Dermatology**, to release any medical information to physicians other than original referring providers, who may be involved in my or my dependent's health care treatment, when requested by these physicians. By signing this consent, information will be given to requesting providers without further signed authorization. I hereby give permission to disclose, discuss and speak to listed individual(s) concerning my medical or financial information including, appointments, test results, prescriptions, school or work excuses, etc. (We ***must*** have each individual listed by name. This includes your spouse, children, parents, etc.)

☐ **RELEASE MY MEDICAL INFORMATION TO:**

Name ______________________ Phone __________ Relationship ______________

Name ______________________ Phone __________ Relationship ______________

Name ______________________ Phone __________ Relationship ______________

☐ **RESTRICT/DO NOT RELEASE ANY INFORMATION**

May we leave personal information on your answering machine? **Yes No** ***Text to your cell phone?*** **Yes No**

Send to your email address? **Yes No**

☐ **I request to be web enabled thru *eClinical Works* for secure access to information related to my care. I will be emailed the instructions and password for web access: Email:** ______________________________

Do you have an *Advanced Directive (Living Will)*? Yes No If YES, does anyone make medical decisions on your behalf? Yes No

Medical Decision Maker Name: ______________________ **Phone:** ______________

PLEASE INITIAL EACH SECTION BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE INFORMATION:

_______ **ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY**

I do, hereby authorize payment of my insurance benefits, including authorized Medicare benefits, basic and major medical for the services I receive, to be made directly to **Coastal Skin Surgery and Dermatology.**

_______ **CONSENT FOR MEDICAL SERVICES**

I authorize **Coastal Skin Surgery and Dermatology** to render treatment to me or my dependents for dermatological care or medical procedures as deemed medically necessary for treatment as indicated.

_______ **REFERRALS/AUTHORIZATIONS**

I understand that if my insurance requires a referral or an authorization, I am responsible for obtaining the referral prior to my visit. If I do not have a referral or authorization at the time of my visit, I may be rescheduled or sign a waiver of financial responsibility. In such case I understand that full payment will be required at the time of service.

_______ **FINANCIAL RESPONSIBILITY**

I understand that although **Coastal Skin Surgery and Dermatology** will file a claim to my insurance plan(s), I am expected to pay my copayment, coinsurance, deductible and non-covered services amounts at the time services are rendered. I acknowledge that **Coastal Skin Surgery and Dermatology** does not guarantee payment of my claim by my insurance plan and that it is my responsibility to know the provisions of my insurance. Not all procedures are deemed "Medical Necessity" by insurance carriers and can be considered cosmetic. For example-Skin tag removal, correction of dark spots, yearly skin cancer screenings without specific areas of concern, would not be a covered service. I understand that I would be responsible for payment of such services. I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

I also understand that any prior unpaid balances on my account must be paid in full before being seen by a provider. If my prior balance cannot be paid in full, I will speak with a financial counselor at **Coastal Skin Surgery and Dermatology** to make a payment arrangement before services can be rendered.

I also understand that if **Coastal Skin Surgery and Dermatology** does not participate with my insurance plan that I will be expected to pay in full for my services. And it is my responsibility to know if **Coastal Skin Surgery and Dermatology** is in network with my insurance plan.

I understand that payments to **Coastal Skin Surgery and Dermatology** can be made by cash, checks and all major credit cards. I also acknowledge that returned checks will be subject to a non-sufficient fund fee of $25.00.

_______ **COSMETIC SERVICES**

Cosmetic services are not a covered benefit under insurance plans. I understand that to make an appointment for cosmetic services, I will be expected to pay half of the service as a down payment and be expected to pay the remaining balance when services are rendered.

_______ **PATIENT RESPONSIBILITY**

I understand that due to Federal (red flag) rules that **Coastal Skin Surgery and Dermatology** is prevented from filing to my insurance without proof of identification. I will be expected to present a photo ID and insurance card(s) at every office visit. I will also update any changes to my addresses, telephone numbers and insurance if they have changed since my last visit and I understand that I will be asked to update my demographics and signatures annually.

_______ **MISSED APPOINTMENTS**

It is my responsibility to notify **Coastal Skin Surgery and Dermatology** at least *48 hours* prior to my appointment if I am unable to keep the appointment. I acknowledge that if I miss two appointments without sufficient notification that I will be charged a **$50** fee. If I miss three appointments without sufficient notification, I will be dismissed from the practice for non-compliance.

_______ **PRIVACY POLICY NOTICES**

I have been offered a copy of **Coastal Skin Surgery and Dermatology's *Notice of Privacy Policies*** that details how my personal health information may be used, disclosed and my rights as permitted by federal law. As well I understand that this notice is posted for my benefit in the reception areas and on the website of **Coastal Skin Surgery and Dermatology**.

_______ **ePRESCRIBING CONSENT**

I acknowledge that **Coastal Skin Surgery and Dermatology** utilizes electronic health records and will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my pharmacy provider. To enable electronic prescriptions to my pharmacy, I grant **Coastal Skin Surgery & Dermatology** my permission to access my medication history to view current and past prescription information.

_______ **LAB SERVICES**

I am aware that my laboratory/pathology services may not be billed from **Coastal Skin Surgery and Dermatology**. I will receive a separate statement from the lab or pathologist. In addition it is my responsibility to contact my insurance plan to determine what laboratory is in network for my plan.

PATIENT/GUARDIAN SIGNATURE: ____ **DATE:** ____________________

WITNESS: ____