## PATIENT INFORMATION - PLEASE PRINT

*Today's Date* ___/___/___

*Name* _____
Last First M.I.

*Mailing Address* _____
City State Zip

*Home Phone* _____ *Work Phone* _____ *Cell Phone* _____
Area Code Area Code Area Code

*Date of Birth* ___ / ___ /___ *Age* ___ *Sex* ___ *Marital Status* ___ *Occupation* _____ *SS #* _____

Referred by: ___ Family ___ Yellow Pages ___ Insurance Co. Pharmacy _____

Primary Care Physician _____ / _____

## PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name _____
*Last* *First* *M.I.*

Address _____
*City* *State* *Zip*

Home Phone _____ Work Phone _____ SS# _____
*Area Code* *Area Code*

Date of Birth ___ / ___ /___ Sex _____

## INSURANCE INFORMATION (Please present insurance card at time of check in.)

**Primary** Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group# _____

Employer Name _____

Employer Address _____

Employer Phone _____
*Area Code*

Relationship of patient to the Insured _____

**FOR MEDICARE PART B:** **HAVE YOU RECENTLY JOINED A MEDICARE HMO? YES ___ NO ___**

I request that payment of authorized Medicare benefits be made to BAY RIDGE SKIN & CANCER for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and **THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON COVERED SERVICES.** Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**MEDICARE Beneficiary Signature** _____

### FOR ALL OTHER INSURANCE:

I understand that it is my responsiblity to have proper authorization for **every visit** at BAY RIDGE SKIN & CANCER, DERMATOLOGY. **Applicable co-payments apply to each visit.**

In the event my referral is invalid due to **expired date,** or **terminated coverage I understand I will be responsible for FULL payment for services rendered.**

For "Out of Network", "Freedom", "PPO" and/or non participating plans **I understand that deductibles and coinsurance (in addition to co-payment)** may apply according to the terms of my contract **and I will be billed for any amount my insurance company determines to be my responsibility.**

PATIENT SIGNATURE* _____
*(Under 18, parent or guardian must sign above)

I acknowledge that I have received a copy of Bay Ridge Skin & Cancer Dermatology P.C.'s "Notice of Privacy Practices".

_____ _____
Signature of Patient Date
(Under 18 parent/guardian must sign)

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