



Patient Information Sheet

Please fill out the entire form. If a question does not pertain to you please write N/A (non-applicable).

Last Name _____ First Name _____ Patient ID # _____

DOB _____ Sex M / F SS# _____ Marital Status Married Single Divorced Widowed _____

Home # _____ Cell # _____ Work # _____

Florida Address _____ City _____ State _____ Zip _____

Alternate Address _____ City _____ State _____ Zip _____

Employer _____ Employer Phone # _____

PCP (Primary Care Doctor) _____ City, State _____

Which doctor referred you here? _____ City, State _____

Pharmacy _____ City and cross streets _____ Pharmacy Phone # _____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

If Race, Ethnicity, or Language is incorrect please correct below:

Race: _____

- American Indian/Alaska Native Nat. Hawaiian/Pacific Islander
- Asian Other Race _____
- Black/African American White
- Declined

Ethnicity: _____

- Declined
- Hispanic or Latino
- Not Hispanic or Latino

Primary Language: _____

Insurance Information

Insurance company plan _____ City _____ State _____ Zip _____

Subscriber: self / spouse name _____

SS# _____ Relationship to Subscriber _____ DOB _____ Phone # _____

Subscriber's Address _____ City _____ State _____ Zip _____

Secondary Ins. _____ Policy # _____ Group # _____

Ins. Address _____ City _____ State _____ Zip _____

Subscriber _____ Relationship _____ DOB _____

Subscriber's Address _____ City _____ State _____ Zip _____

Is this a work related injury? Y / N Is this related to an auto accident? Y / N

CONTINUED ON THE OTHER SIDE

DERMATOLOGY ASSOCIATES OF THE PALM BEACHES

Financial & Office Policies

Thank you for choosing us as your healthcare provider. We care about our patient's physical and financial well being and welcome the opportunity to work with you on any billing issue that may arise. We have implemented a new financial and office policy stating our expectations and options for payment.

I assign all medical and / or surgery benefits, to include "major medical" benefits, which I am entitled inclusive of Medicare and all other health payments this association is entitled. Payment is due at the time services are provided unless other plan(s) have been set up. I understand you do not accept assignment in the case of liability actions.

Insurance Billing

Though Dermatology Associates of the Palm Beaches accepts most insurance plans, I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Insurance Referrals

If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

Self Pay

If I am un-insured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

Patient Billing

I understand that I will be sent a **single** monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. **If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collections agency. I will be responsible for any reasonable cost of collection including credit checks, court costs and attorney's fees.** If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements. I understand that if my check is returned, I will be charged a fee of \$50.00

I authorize the release of medical record information to: 1) the above named insurance companies, 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

Co-payments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any services provided by Dermatology Associates of the Palm Beaches. I understand that I am financially responsible for payment of any services rendered to me by Dermatology Associates of the Palm Beaches. I have read and accept the terms of this policy.

Signature _____

Date _____