SOUTHEASTERN SKIN CANCER & DERMATOLOGY PATIENT REGISTRATION FORM

Name _____ Today's date _____
Last First M.I.

Mailing Address _____ Age _____
Number, Street, Apartment Number

_____ Email _____
City State Zip

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____) _____

Date of Birth _____/_____/_____ SS # _____ Marital Status _____ Gender _____

Employer_____ Retired _____ Full Time Student____ Part Time Student _____

Spouse's Name: _____ Employer _____ Work # _____

Person to notify in case of emergency _____ Phone _____
(Please list a person not living in your home)

Referring Doctor or Person_____

Contact Methods

May we leave a message on your home answering machine? Y N May we leave a message for you at work to call us? Y N

May we text you? Y N May we email you? Y N May we discuss your medical condition with another person? Y N

If yes, whom _____ Relationship _____

How did you hear about our practice? _____

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Primary Ins_____Pol#_____Grp#_____Policy Holder_____DOB_____Rel_____

Secondary Ins_____Pol#_____Grp#_____Policy Holder_____DOB_____Rel_____

Tertiary Ins_____Pol#_____Grp #_____Policy Holder_____DOB_____Rel_____

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If patient is a minor please enter responsible party information. (Note: *We do not bill absent parents, the adult presenting the minor for care is the responsible party.*)

Name _____ SS# _____
Last First M.I.

Address_____
_____
City State Zip

Home Phone (_____)_____ Work Phone (____)_____ Cell Phone (_____)_____

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PLEASE PRESENT THIS FORM, YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST

CREDIT CARD AUTHORIZATION (Optional)

If you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient. We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

I authorize Southeastern Skin Cancer & Dermatology, its Doctors, and/or staff to issue charges to my credit card account (shown below) under the following circumstances:

INITIALS

_____ I understand that I am responsible for payment of the following charges at the time of service: deductibles, services not covered by my insurance policy, medically unnecessary/cosmetic services, co-payments, and insurance balances from previous appointments (should my primary insurance be with a company with which Southeastern Skin Cancer & Dermatology is contracted).

_____If my insurance company is not one with which Southeastern Skin Cancer & Dermatology is contracted, I am responsible for the entire amount of charges at the time of service. I acknowledge that a representative of Southeastern Skin Cancer & Dermatology billing department is available to explain the charges to me and I agree with this amount.

_____ If, after my insurance pays on my claims and a patient balance becomes due to Southeastern Skin Cancer & Dermatology, I authorize this office to generate charges to my major credit card account for that unpaid balance without further permission or notice.

_____ I request a Receipt for Charges to be mailed to my address.

_____VISA _____MASTERCARD _____DISCOVER

CREDIT CARD # _____--_____--_____--_____

EXPIRATION DATE _____/_____ 3-DIGIT CODE# _____
Month / Year

NAME AS IT APPEARS ON THE CREDIT CARD:
_____

Signature: _____ Date: _____

****Please provide Southeastern Skin Cancer & Dermatology with a photocopy of your credit card and your driver's license**

PATIENT FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS
Southeastern Skin Cancer & Dermatology

Please sign the form below:

I hereby authorize payment by an insurer directly to Southeastern Skin Cancer & Dermatology for all benefits payable under the terms of the insurance policy during the period of the services rendered. Your fees are only for services performed at or by our practice. There may be other fees associated with pathology, lab work or other related medical care not affiliated with our office. This office has contracts with Medicare and with many managed care plans. Please check with our reception staff to determine whether your plan is one of these. However, it is ultimately the responsibility of the patient/guarantor to determine if Southeastern Skin Cancer & Dermatology is a participating provider.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of service. If arbitrary determination of a participating insurance company determines that services are cosmetic or not medically necessary, the patient/guarantor will be responsible for the outstanding balance. If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service. If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

Payment in full is expected on outstanding balances. In the course of outstanding balances, two statements will be generated, after which, a notice prior to collections will be mailed. If a payment plan is necessary, terms and conditions will be determined solely by Southeastern Skin Cancer & Dermatology, not by the patient/guarantor. There will be a 50% charge added to the outstanding balance due plus required postage if the debt is referred to a collection agency for collection. If legal action is necessary, the associated fees assigned will be added to the fees incurred from medical treatment. Printing of any records for legal, life insurance, personal or other reasons will be charged based on number of copies to cover labor and supplies.

For your convenience in paying, this office accepts Visa, Master Card, Discover and American Express in addition to cash and checks. There will be a $50 fee for any returned checks. Because we make every effort to see patients on time, we do not overbook to accommodate patients who do not keep their appointments. Therefore the practice has the option to charge for missed appointments not cancelled with at least one business days' notice. The first missed appointment without significant notice will be charged $50.00 and each additional missed appointment will be charged $75.00. All missed surgical appointments without significant notice will be charged $150.00 for the first missed appointment and each additional surgical appointment missed will be charged $300.00.

Any person signing this document as a "guarantor" agrees to payment and fees as described above for the patient noted below. I certify that I have read the financial policy of Southeastern Skin Cancer & Dermatology, and agree to abide by the policy.

I authorize my insurance company to pay benefits on my behalf directly to Southeastern Skin Cancer & Dermatology. I authorize Southeastern Skin Cancer & Dermatology to provide to my insurance company any information necessary to process claims for services rendered to me.

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? Yes No

Are you covered by any other insurance that makes Medicare secondary? Yes No

Patient Name_____Signature of Patient/Guarantor_____Date_____

Southeastern Skin Cancer & Dermatology
ACKNOWLEDGEMENT OF RECEIPT
(NOTICE OF PRIVACY PRACTICES)

Southeastern Skin Cancer & Dermatology
8331 Madison Boulevard, Suite 300
Madison, Alabama 35758
(256) 705-3000

I understand that, under the Health Insurance & Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the organization (Southeastern Skin Cancer & Dermatology) has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ **Initials:** _____

Reason(s):_____