Palmetto Dermatology Circle Location: W/C LEX NBY

Today's Date __________________ Referring Physician________________________________ Chart #__________________

PATIENT INFORMATION (MUST COMPLETE IN FULL)

Patient's Full Name ____ SSN ____

Billing Address ____City____________________State____________Zip Code__________________

Home Phone No. _______________________Cell Phone No. __________________Birthdate____________M/F _____________________

Palmetto Dermatology may leave an appointment reminder on the following preferred contact number: ______________________________

Marital Status____________Student____________Employment: (F / PT / Retired / UnEmp) ____

Employer____Work No.____

Patient Relationship to Insured__________________Self________________Spouse_______________Dependent____________________________

SPOUSE/PARENT/GUARDIAN/POWER OF ATTORNEYS INFORMATION (MUST COMPLETE IN FULL)

Name____SSN________________________Birth Date__________________M/F___________

Billing Address(If Different)____

City________________________State_________Zip Code____________Phone no. (If different)____

Employer____Work No.____

Who would you like for us to notify in case of emergency? ____

Name__________________________________Relationship____________________________Phone No.______________________________________

PRIMARY INSURANCE TO FILE (MUST COMPLETE IN FULL)

Insurance Company ____

Policy holders Name____Policy holders Birth Date_________________________ M/F________________

Group No.__________________________Policy/ID No._____________________________Policy holders SSN____________________________________

SECONDARY INSURANCE TO FILE

Insurance Company ____

Policy holders Name____Policy holders Birth Date__________________________M/F________________

Group No.__________________________Policy/ID No._____________________________ Policy holders SSN____________________________________

THERE WILL BE AN ADDITIONAL $20.00 BILLING FEE FOR CO-PAYS AND/OR CO-INSURANCE NOT COLLECTED AT TIME OF SERVICE.

*** Cancelation Policy –** All Office visits require a 24 hour notice or there will be a $50.00 charge. All surgeries require a 48 hour notice or there will be a $100.00 charge.

I hereby authorize assignment of benefits for all medical claims pertaining to Palmetto Dermatology to be made to them. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release of all medical information necessary to secure the payment from said insurance companies. However, I understand that I am financially responsible for all services rendered to me. I understand that I am responsible for any amount not covered by my insurance. If this account has to be turned over for collection, the undersigned guarantor agrees to pay attorney fees if necessary and all collection fees, which is an additional charge above your normal charge. There will be a $35.00 charge added to your account on all returned checks. There will be a $35.00 charge added to your account for any balances that are 90 days past due and not paid in full. I have read and fully understand Palmetto Dermatology's, Financial Policy given to me. I guarantee that I am of legal age.

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Patient and/or Responsible Party Signature Date