Palmetto Dermatology

Today's Date__________________ Referring Physician________________________________ Chart#_____________________

*Patient Information (Must Complete in Full)

Patient's Full Name____**SS#**_______________________________________

Billing Address____**City**_________________**State**____________**Zip Code**___________

E-mail____**Primary Phone #**____________________________ **Secondary Phone #**__________________

Birth date________________________ **M/F** **Marital Status**_____________________ **Student**__________________

Employer: (FT/PT/Retired/Un-Employed) ____

Emergency Contact______________________________________**Relationship**_______________**Phone #**_________________

Parent (If Child is under 18 Years of Age)/Guardian/Power of Attorney Information (Must Be Completed in Full by the Person Signing this Form)

Name____**SS#**_______________________________________

Billing Address____**City**____________________**State**____________**Zip Code**__________

Home #____________________________________**Cell Phone #**________________________________**Work #**__________________________

Birthdate______________________ **M/F** **Marital Status**______________________

*Primary Insurance (In Addition to a Copy of Your Card *This Form Must be Completed In Full or Insurance CAN NOT be Filed)* *If patient does not have the physical card, patient is responsible for the bill.*

Insurance Company____**Deductible**_________________**Copay**_________

Policy Holders Name____**Policy Holder's Birth date**__________________________ **M/F**

Policy ID #_________________________________**Group #**____________________**Policy Holders SS#**__________________________________

Policy Holders Employer____

*Secondary Insurance (In Addition to a Copy of Your Card This Must be Completed in Full or Insurance CAN NOT be Filed)

Insurance Company____**Deductible**________________**Copay**__________

Policy Holders Name____**Policy Holders Birth date**_________________________ **M/F**

Policy ID #_________________________________**Group #**______________________**Policy Holders SS#** _______________________________

Policy Holders Employer____

Financial Policy: ***All fees, co-pays and outstanding balances will be collected up front upon arrival at check-in. All cosmetic fees will be required to pay at the time of service. If you do not know your insurance co-pay, deductible or coinsurance a $50.00 payment will be collected at time of service.

Cancellation Policy: All office Visits require a **24 hour notice** or there will be a $50.00 charge. All procedures and or surgeries require a **48 Palmetto Dermatology (Monday through Thursday) business hour notice** or there will be a **$150.00 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 the 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 guarantee that I am of legal age.

*____ ____________________________________

Patient or Responsible party if patient is under 18 or disabled **Date** **Revised: 6-24-19**