

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.

* Cancellation 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.

Patient and/or Responsible Party Signature

Date