Davie Dermatology & The Med Spa

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Patient Registration **Account #_____**

Patient Information:

(Check one the following): □ New Adult Patient □ New Minor (under 18) Patient □ Annual

If used for update: □ Name Change □ Address Change □ Insurance Change □ Permission Change

Print Name: _____ Date of Birth: _____

Last *First* *Initial*

Patient Social Security #: _____

Patient Home Phone #: _____ Patient Work Phone #: _____

Patient Mobile Phone #:_____ Birth Sex: □ Male □ Female

Mailing Address: _____

Street *City* *State* *Zip*

Primary Care/Family Physician: _____Primary/Family MD Phone #: _____

Referring Physician: _____

Patient Email Address (Parents if minor): _____

Insurance Information:

Primary Insurance: _____

Name of Policy Holder: _____ Policy Holder D.O.B. ___/___/___

Secondary Insurance: _____

Name of Policy Holder: _____ Policy Holder D.O.B. : ___/___/___

DO WE HAVE PERMISSION TO?

Leave a message on your home or cell phone? □Yes □No

Leave a message at your place of employment? □Yes □No

Whom may we discuss medical information about the patient with?

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, whom should we notify? _____

Relationship to Patient: _____ Phone # _____

PLEASE PRESENT YOUR INSURANCE CARD(S) AND YOU'RE PHOTO IDENTIFICATION TO THE RECEPTIONIST.

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FINANCIAL POLICY- Revised 09/11/18

Welcome and thank you for choosing Davie Dermatology for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs. We are happy to provide you with an itemized statement at any time. Our Business Office will be pleased to discuss with you any questions you may have concerning a bill**. Labs and pathology bills will be charged by a third party separately.**

Cosmetic Fees: All cosmetic fees and balances must be paid at the time of service. You will be asked to pay at check-in all unpaid balances for Cosmetic services before you can be seen for your scheduled or next appointment.

Patient Payments: Co-pays, deductibles, and services not covered by your insurance plan, as well as, outstanding balances are due at the time of service. We will mail you (3) three statements reflecting any balance due. A $5.00 billing fee will be charged to your account for each additional statement we send you. As a courtesy to our patients, we accept cash, personal check, money orders, and all major credit cards (Visa, Master Card, Discover and American Express). Returned checks will be subject to a $25.00 fee. You will be asked to present one of the above for payment at the time of service. If payment is not made at the time of service, you will be asked to speak with our Business Office Staff to set up a payment plan that is acceptable to both you and our office. Any balances due must be paid before any upcoming appointments. If you arrive for an appointment, and you have a balance on your account, you will be asked to pay the balance or reschedule your appointment. Any exceptions to this must be discussed with our Business Office Staff. It is important that you understand our financial policy, and make us aware of any financial hardships you may have. Unpaid balances may result in discharge from the practice and/or referral to a collection agency. Any overpayments or refunds (over $5.00) will be processed after active or past charges are paid in full. Refunds are issued to the appropriate party according to the registration and insurance forms. Refunds (under $5.00) will be held as a credit on the patients account unless the patient requests refund of the amount under $5.00.

Past Due Accounts: All fees not covered by your insurance will be charged a past due balance fee in the amount of 25% of the unpaid balance (Minimum Charge of $25.00) should your account be sent to collections.

Insurance Payments: Your insurance coverage and benefits are a contract between you and your insurance company, all disputes must be handled between you and your insurance company. We are contracted with multiple insurers to accept assignment of benefits. If you have an insurance coverage with a plan in which we do not have a contract, you will be considered as a "self-pay" patient and payment is due at the time of service.

WE ARE NOT A CONTRACTING PROVIDER FOR THE FOLLOWING PLANS

1. BLUE CROSS BLUE LOCAL PLAN **2**.MEDCOST EXLUSIVE PLAN/WAKE/CORNERSTONE.

If your insurance policy requires a referral for a specialist, such as a dermatologist; it is the patient's responsibility to be sure that a referral has been sent to our office **before** your visit with the provider. Failure to obtain the required referral before your visit will result in you being financially responsible for your bill. Providing that we have on file your correct insurance policy information and any required referral forms we will file up to two separate insurance claim forms free of charge for each service you receive.

Cancellation / Rescheduled Appointments / No-Show Fees: We understand that situations arise in which you must cancel/reschedule your appointment. It is requested that if you must cancel your appointment, you provide more than 24 hour notice.

- Office appointments which are cancelled with less than 24 hours' notice will be subject to a $50.00 cancellation fee. Surgery cancellations require 72 hour notice, without notification, they will be subject to a $75.00 cancellation fee.
- Patients who miss their scheduled appointment without a call to cancel will be considered a NO SHOW and be subject to a $50.00 fee for an office appointment and a $75.00 fee for a procedure or surgical appointment.

Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full within 90 days or they will be subject to our, "Past Due Account," policy above. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived by practice management. Questions regarding cancellation and no show fees should be directed to the Business Office.

Medical Forms: Completion of disability forms, attending physician statements, and other supplemental insurance forms require physician and/or staff time to complete and will require a $25.00 fee to complete most of these forms. Non-standard forms may be higher.

Walk in Visit: Please note that if a patient comes in without an appointment to speak to a provider, there may be a charge for that visit depending on the complexity of care or services provided.

Product Returns: All product returns must be present with receipt and returned within 30 days of purchase for exchange or refund.

Statement: I hereby authorize payment directly to Davie Dermatology P.A. of the surgical and/or medical benefits. I hereby authorize Davie Dermatology, P.A. to release my information required in the course of my examination and/or treatment to my insurance carriers, third party payers or others directly involved in processing and collection of any claims submitted on my behalf. If patient is a minor (Under 18) the Parent/Adult/Guardian **who signs this form below** will be responsible for all copayments, deductibles and non-covered services. We do not forward bills to other parties regardless of court rulings or divorce decrees.

I guarantee payment to Davie Dermatology, P.A for all charges for services provided to me. I understand that the person signing below as Financially Responsible Party is personally responsible for all copayments, deductibles and non-covered services. I authorize payment directly to Davie Dermatology, P.A. for any surgical or medical benefits, if any, and otherwise payable to me for all services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct. I authorize the transfer of monies paid to Davie Dermatology, P.A. and otherwise refundable to the Patient or Guarantor, to other accounts at Davie Dermatology for any other account which the Patient or Guarantor is responsible. I understand Davie Dermatology, and any affiliates, or vendor thereof (including collection or billing companies) may contact me by: phone, voice message, or text message to any telephone number (home, work, wireless, cellular, and/or mobile) I have provided or associated with my account. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Davie Dermatology, P.A. if I have given up ownership or control of any such telephone number.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL POLICY TO ENSURE PAYMENT FOR MYSELF OR MY FAMILY. I UNDERSTAND THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME, THE PATIENT OR LEGAL GUARDIAN. I have also received a copy of the Davie Dermatology notice of privacy practices on this date.

Name: _____ Date: _____

Patient Signature: _____ Account #: _____

If patient is a minor or patients parent is taking financial responsibility, please complete the below section and sign.

******FINANCIALLY RESPONSIBLE PARTY-** ***Person responsible for the payment of all non-covered services***

Print Name: _____ _____ _____ Date of Birth: _____

First *Last* *Initial*

Social Security #: _____ Home/Cell #: _____ Work #: _____

Mailing Address: _____ _____ _____ ____

Street *City* *State* *Zip*

Responsible Party Signature :_____ Date:_____

Patient name: _____ Date of Birth: _____

We are honored that you have chosen Davie Dermatology for your dermatologic care.

Please take a few minutes to tell us a little more about yourself.

1. **Have you ever been diagnosed with any of the following (check any that apply):**
   ___ Heart disease ___ HIV or AIDS
   ___ Cancer (other than skin) ___ Kidney disease (or on dialysis)
   ___ Diabetes ___ Blood disorders/bleeding problems
   ___ Thyroid disease ___ High blood pressure
   ___ Hepatitis ___ Anemia
   ___ Arthritis/joint pains ___ Keloid scars
   Other: _____
   _____
2. **What medications are you currently taking?**
   _____ _____
   _____ _____
   _____ _____
   _____ _____
3. **Have you ever been diagnosed with skin cancer?** ___Yes ___No
   If yes, what type? ___Squamous cell carcinoma ___Basal cell carcinoma ___melanoma ___other
   What year was the most recent diagnosis? _____
4. **Are you allergic to any medications?** ___Yes ___No
   If yes, which medications?_____
   _____
5. **Do you have a cardiac pacemaker or defibrillator?** ___ Yes ___ No
6. **Do you ever need to take antibiotics before having your teeth cleaned or having surgery (due to heart valve disease/replacement, joint replacement, etc.)?** ___ Yes ___ No
7. **Has anyone in your immediate family been diagnosed with (check all that apply):**
   ___ Non-melanoma skin cancer (basal cell or squamous cell carcinoma)
   If yes, which relative (mother, father, etc.)? _____
   ___ Melanoma
   If yes, which relative (mother, father, etc.)? _____
   ___ Psoriasis
   ___ Eczema
8. **Have you experienced any of the following in the last month: (check all that apply):**
   ___ Shortness of breath/wheezing ___muscle aches/joint pains ___ headaches
   ___fever/chills ___fatigue ___nausea/vomiting/diarrhea