PUGET SOUND
DERMATOLOGY
BOARD CERTIFIED DERMATOLOGISTS

Patient Information

Last_____First_____M.Initial_____

Social Security#_____ Date of Birth _____/_____/_____ Gender: M F

Address_____City_____State_____Zip _____

Home Phone_____ Day Phone _____ Work Phone_____

Employer _____

Email _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Life Partner ❑ Widowed

Preferred Language: _____ Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Referring Physician: _____ Location: _____

Primary Care Physician:_____ Location: _____

Primary Insurance

Insurance Company: _____

Subscriber Name: _____ Date of Birth _____/_____/_____

Relationship to patient: (circle one) (a) Self (b) Spouse (c) Parent (d) Other _____

Secondary Insurance

Insurance Company: _____

Subscriber Name: _____ Date of Birth _____/_____/_____

Relationship to patient: (circle one) (a) Self (b) Spouse (c) Parent (d) Other _____

If you have medical insurance, we will do all we can to help you receive your maximum allowable benefits. To accomplish this, we need your assistance, and your understanding of our policies:

- ***Insurance Plans:*** All contracted insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits, deductibles, and co-insurance are your responsibility. Payment for any patient responsibility is due upon receipt of your monthly statement.
- ***Co-Pays:*** All co-pays are expected at the time the service is rendered. It is your responsibility to notify the receptionist upon arrival that you have a co-pay. A $20.00 handling fee maybe added to your statement if you do not pay your co-pay at the time of service.
- ***Returned Checks:*** There will be a $35.00 charge for all returned checks.
- ***No Show/Cancellation Policy:*** There may be a $50.00 charge for no-show appointments or cancellation of appointments without a minimum 24-hour advance notice.
- ***Benefits/Coverage:*** It is your responsibility to understand your insurance benefits. Insurance coverage is not a guarantee of payment for services provided. Intentional misrepresentation of insurance information is considered fraud and may be prosecuted under the laws of this state.
- ***Referrals/Authorizations:*** If your health plan requires a referral or pre-authorization, it is your responsibility to obtain the proper documentation from your PCP prior to your appointment at our clinic. If a referral is not in place your appointment may be rescheduled.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. The information I have provided is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits from my insurer, including Medicare and Medicaid, directly to Puget Sound Dermatology. By signing this form, I am accepting financial responsibility for payment of medical services provided by Puget Sound Dermatology and other medical facilities for services that are necessary for my diagnosis or treatment. I acknowledge that insurance billing services provided by Puget Sound Dermatology is a courtesy and does not relieve me of financial responsibility for services provided. This assignment of benefit shall remain in effect as long as I receive treatment from Puget Sound Dermatology.

SIGNED _____ **DATE** _____