DERMATOLOGY SPECIALISTS OF CANTON

PHYSICIAN: _____

DATE: _____

PATIENT INFORMATION

_____ _____
(First, Middle, Last Name) (Date of Birth)

_____ _____
(Address) (City, State, Zip Code)

_____ _____
(Email Address) (Social Security Number)

_____ _____ _____
(Phone Number) (Work Phone Number) (Cell Phone Number)

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**
Sex: ☐ **Male** ☐ **Female**

PRIMARY INSURANCE INFORMATION

_____
(Name of Insurance Company)

_____
(Subscriber's Name) (Date of Birth)

_____
(Subscriber's Employment) (Relationship to Patient)

SECONDARY INSURANCE INFORMATION

_____
(Name of Insurance Company)

_____
(Subscriber's Name) (Date of Birth)

_____
(Subscriber's Employment) (Relationship to Patient)

REFERRING PHYSICIAN

_____
(Name)

_____
(Address)

_____
(City) (State, Zip Code)

_____
(Phone)

PRIMARY CARE PHYSICIAN

_____
(Name)

_____
(Address)

_____
(City) (State, Zip Code)

_____
(Phone)

PATIENT EMPLOYMENT

_____
(Name)

_____
(Postition)

_____
(City) (State, Zip Code)

_____
(Phone)

PHARMACY

_____
(Name)

_____
(City) (State, Zip Code)

DRUG ALLERGIES

MEDICATIONS

Please include strength and how often taken

CONSENT TO EXAMINATION AND TREATMENT:

I understand and voluntarily consent to receive medical and health care services given by Dermatology Specialists of Canton, will be referred to as "DSC" for the remainder of this document. I understand the examination procedures will be explained to me and I authorize the administration of all diagnostic and therapeutic procedures, examinations and treatments considered advisable or necessary in the judgment of the physician. I understand that the examination results will be provided to me with recommendations. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow up examinations to check abnormalities found and treated, lies with me and not with DSC. I hereby release my examiner from all responsibility in connection with the examination. I understand that in order for the doctor to give me the best medical care possible, I must follow instructions and notify the office if I have problems with my medications or treatment.

CANCELED OR MISSED APPOINTMENTS:

We are happy to reschedule any appointment for you. We do request Twenty-four (24) hour notice of a cancellation/rescheduled appointment. It is our aim to accommodate you the patient. We have patients eager to use your canceled appointment time. We reserve the right to charge a cancellation fee of twenty five dollars ($25) for appointments not canceled/rescheduled 24 hours in advance. We hope you, our valued patient, will cooperate in this simple request.

FOR PROCEDURE APPOINTMENTS:

We require 48 hour notice for cancellation/reschedule of procedure appointments. These appointments include but are not limited to: complete skin examinations, biopsies, excisions, and cosmetic procedures. For procedure appointments not canceled 48 hours in advance there will be a cancellation fee of fifty dollar ($50).

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

MEDICARE ASSIGNMENT OF BENEFITS (PERTAINS TO ALL MEDICARE RECIPIENTS ONLY):

I authorize payment to be made to DSC. I authorize any holder or medical information about me to release to my insurance carrier and or HCFA and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

INSURANCE LEGAL ASSIGNMENT OF BENEFITS:

I acknowledge that as a courtesy DSC will file a claim on my behalf. I authorize payment to be made to DSC. I authorize any holder or medical information about me to release to my insurance carrier any information needed to determine these benefits or the benefits payable for related services. I hereby authorize DSC to give my insurance company all information concerning every condition for which I have been under observation or treatment, the history obtained, physical and laboratory findings, diagnosis and treatment. I authorize payment of medical benefits to the physician for services rendered. I also understand that if any charges are not covered by my insurance carrier or if my insurance benefits are terminated, I will be responsible for payment of all charges.

FOR PATIENTS WITH NO INSURANCE COVERAGE:

I acknowledge I am financially responsible for all charges for services and payment is expected at the time of service unless other arrangements have been made in advance for a payment plan.

RELEASE TO LEAVE CONFIDENTIAL MESSAGES (APPOINTMENT REMINDERS, DIAGNOSTIC TEST RESULTS):

I hereby authorize DSC to leave confidential messages on my telephone answering machine or voice-mail. I am authorizing the following telephone numbers to be used for authorized calls or other health care information if other than home telephone number(s): *I am fully aware that a cell phone is not a secure and private line.

ACKNOWLEDGMENT OF REVIEW: PRIVACY PRACTICES:

I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I am aware that I am entitled to review Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I hereby authorize DSC to release any information in the course of my examination or treatment as needed to process my insurance claims and to inform my private physician as to my course of treatment.

Patient Signature: _____ Date: _____