HILTON HEAD DERMATOLOGY & SKIN CANCER CENTER, P.A.
LASER & SKIN SURGERY CENTER

PLEASE PRESENT INSURANCE CARD (S) TO RECEPTIONIST

PLEASE PRINT CLEARLY

Today's Date_____

Patient Name_____ Date of Birth_____ Sex _____
First MI Last

Home Address_____ Cell Phone # ( )_____
Street City State Zip Home Phone # ( ) _____
Work Phone # ( ) _____

Billing Address_____ Email Address _____@_____
Street City State Zip

Employer_____ Occupation _____

Social Security# _____Driver's License#_____ State _____

Emergency Contact _____ Second number different from above phone ( ) _____

Person Responsible for Payment _____ Relationship_____ Phone ( )_____

Who may we thank for referring you to us? _____ Marital Status: M S D Race: B W Other _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder_____ Insurance Co. _____

Insurance Company Address_____ Phone ( )_____

Policy #_____Policy Holder Date of Birth_____ Group #_____

SECONDARY INSURANCE

Name of Policy Holder _____Insurance Co. _____

Insurance Company Address_____ Phone ( )_____

Policy #_____Policy Holder Date of Birth _____ Group#_____

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES:

I authorize payment of medical/surgical benefits to the named provider for professional services rendered. I also authorize the release of any medical information necessary to process this claim, to process any laboratory or pathology specimens, to communicate with other physicians and family members/guardians as a part of my care, and to use any photographs for teaching purposes. I am aware that a copy of the Notice of Privacy Practices is available in the reception area. I understand that my health information is protected.

Signed_____ Date_____
(Subscriber or parent if patient is a minor)

ACKNOWLEDGEMENT NOTE:

Your insurance policy is a contract between you and your insurance company so we cannot guarantee payment on claims. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is *not* a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is *your* responsibility to pay any deductible amount, co-insurance, and all other balances not paid by your insurance company. It is also *your* responsibility to advise the billing office of any required pre-authorization needed for your insurance. It is customary to pay for all services when rendered. Any dishonored returned check will result in a $35 check charge. Required lab work or additional operative time in the surgery center will be billed separately to you by the lab or the surgery center. All charges related to additional procedures or complications for revisions are the full responsibility of the patient. This office will file for insurance benefits on plans in which we participate. We accept assignment on Medicare's fee schedule. Necessary information will be supplied to you to enable you to file your own claim on other plans. You are responsible to this office for all fees not paid within 45 days, regardless of insurance coverage, along with collection expenses and/or reasonable attorney fees. I have read and understood the above.

Signed _____ Date_____
(Patient or parent if patient is a minor)

Signed _____ Date_____
(Staff member)

Rev. 07-31-15