EMERALD COAST
DERMATOLOGY

Financial Policy

Thank you for choosing Emerald Coast Dermatology & Skin Surgery Center. Our Financial policies are listed below for your careful review. These policies are intended to make your office visit as pleasant as possible, and enable our Medical Staff provide the highest quality of care that you are accustom to.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone number(s), please notify our office immediately.
3. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder.
4. We will collect your deductible, co-payment, or charge for a non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, and all major credit cards.
5. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
6. If your insurance denies our charges, or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and to be reported to the credit bureau.
7. No show or missed appointments – We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If **two** appointments are missed without cancellation, you will be charged a $25.00 fee. If **three** appointments are missed, you will be dismissed from the practice for non-compliance.

Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office.

Thank you very much for reading and adhering to our policies.

I have read and have a full understanding of the financial policy of Emerald Coast Dermatology.

Signature: _____ Date: _____

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HIPAA CONSENT FORM

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described in our Privacy Policy. You have the right to review our Privacy Policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I, _____ , hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the Privacy Policy of Emerald Coast Dermatology & Skin Surgery Center, P.A.

Please allow the following person(s) to obtain my personal healthcare information. (If none, write NONE)

_____ _____

_____ _____

RESTRICTION REQUEST SECTION

I hereby request the following **restrictions** on the use and disclosure of my health information. (Please describe in detail)

_____

_____

_____ _____

Signature **Date**

EMERALD COAST DERMATOLOGY & SKIN SURGERY CENTER, PA

Welcome to our office. In order to serve you properly, we will need the following information. (Please Print) All information is strictly confidential. **Full Payment is expected when services are rendered.** Thank you for your cooperation.

PATIENTS NAME LAST, FIRST, MI	AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS S M OTHER	SEX MALE FEMALE
STREET ADDRESS		CITY, STATE, ZIP		HOME PHONE ( )	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		EMPLOYER		WORK PHONE ( )	
NEAREST RELATIVE: NAME, ADDRESS & PHONE NUMBER		EMAIL ADDRESS		CELL PHONE ( )	

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	GUARANTOR PHONE NUMBER
PRIMARY INSURANCE COMPANY NAME		POLICY/ ID NUMBER	GROUP NUMBER
SECONDARY INSURANCE COMPANY NAME		POLICY/ ID NUMBER	GROUP NUMBER

MEDICAL INFORMATION

Reason for your visit today?_____ **Drug Allergies** _____

Please list of medications you are currently taking _____

_____

Please list all major illnesses (high blood pressure, diabetes, etc)_____

Do you have a personal history of skin cancer? _____ **Do you have a family history of skin cancer or melanoma?** _____

Financial Policy

Your insurance policy is a contract between you and your insurance company. Emerald Coast Dermatology cannot guarantee payment for any claim. 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. Many companies will pay only fixed allowances for procedures and others will pay a percentage of the charge. It is YOUR responsibility to pay any unmet deductible amount, co-insurance, or any other balance not paid by your insurance company. Professional fees for office service are expected in full at the time of service unless previous arrangements were made IN ADVANCE.

I, hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Emerald Coast Dermatology & Skin Surgery Center, P.A. I authorize release of medical records to my insurance carrier. When charges are filed with your insurance carrier with an assignment of benefits to our office, any fees unpaid ***after 45 days will become the patient's responsibility.*** In case of no insurance. I understand that I am solely responsible for all bills incurred and I am expected to pay when services are rendered. I understand that the removal of benign lesions (moles, barnacles, skin tags, etc) is considered a cosmetic procedure and is not subject to insurance payment. Therefore, fees are my financial responsibility.

Please Note: There will be a $30.00 service charge for returned checks. We reserve the right to charge for appointment cancelled or broken without 24 hours of advance notice. How do you intend to pay? [ ] Check [ ] Cash [ ] Credit Card (MC/Visa, Discover, AMEX)

_____ _____ _____

Signature of Patient **Date** **Recommended By**

PHARMACY	PHARMACY PHONE NUMBER
PRIMARY PHYSICIAN	PHONE NUMBER ( )
PRIMARY PHYSICAN ADDRESS	

PATIENT INFORMATION FORM

	YES	NO		YES	NO		YES	NO
Aspirin/Motrin/Advil…….	☐	☐	**Birth Control Pills…. ……**	☐	☐	**Are you pregnant…….**	☐	☐
Coumadin ……...	☐	☐	**Are you Breast Feeding…..**	☐	☐	**Plan on becoming pregnant.**	☐	☐

REVIEW OF SYSTEMS (Current or Past problems with)

	YES	NO		YES	NO		YES	NO
Blood/Bleeding Disorders...	☐	☐	**Arthritis ….……**	☐	☐	**Cancer (non-skin)…….**	☐	☐
Heart Disease……..…...	☐	☐	**Diabetes (sugar) ……**	☐	☐	**Immunologic Disease ……..**	☐	☐
Kidney Disease……...	☐	☐	**High Blood Pressure……..**	☐	☐	**Latex/Nickel/Food Allergy. .**	☐	☐
Liver Disease or Hepatitis...	☐	☐	**Infectious Disease (TB, HIV)**	☐	☐	**Skin Disease…….**	☐	☐
Lung Disease……...	☐	☐	**Blood Transfusions ……**	☐	☐	**Skin Cancer…….…….**	☐	☐
Thyroid Disease……...	☐	☐	**Psychological Disorders...**	☐	☐	**Melanoma…….**	☐	☐

DO YOU

	YES	NO		YES	NO
Have a pacemaker/defibrillator ……	☐	☐	**Have an artificial joint / heart valve…….**	☐	☐
Take antibiotics prior to dental procedures…….	☐	☐	**Form Keloids ……..**	☐	☐

List Surgeries:

_____

_____

Family History (Check the following medical conditions which have occurred in your family)

Disease	Mother	Father	Sibling	None	Disease	Mother	Father	Sibling	None
Acne……..	☐	☐	☐	☐	**Arthritis…….**	☐	☐	☐	☐
Eczema…….	☐	☐	☐	☐	**Asthma……..**	☐	☐	☐	☐
Hives……	☐	☐	☐	☐	**Cancer……**	☐	☐	☐	☐
Melanoma……	☐	☐	☐	☐	**Diabetes……..**	☐	☐	☐	☐
Psoriasis……..	☐	☐	☐	☐	**Hay Fever……**	☐	☐	☐	☐
Skin Cancer……..	☐	☐	☐	☐	**Lupus …….**	☐	☐	☐	☐

SOCIAL HISTORY

	YES	NO	
Do you live alone? ……	☐	☐	
Do you drink alcohol? ……	☐	☐	**Frequency _____**
Do you use recreational drugs?	☐	☐	**Frequency _____**

Occupation_____ Hobbies/Leisure Activity _____

Patient Signature _____ Date _____