SCSPHYSICIANS
skin care specialty physicians
MOHS & SKIN SURGERY CENTER

PATIENT DEMOGRAPHICS

for on 3/28/2018

Make sure we've got it right!

We strive for accuracy, but sometimes we make mistakes. **We ask all of our patients to *carefully review* all of their information below, and *CORRECT OR FILL OUT* any missing areas every three months or when changes occur.** Inaccuracies can lead to errors in your medical records and problems with insurance processing. Thanks!

LAST Name		**Address**	
FIRST Name		**City**	
Middle Name		**State & Zip**	

Age		**Gender**	
Birthdate		**Home Phone**	
Marital Status		**Cell Phone**	
Spouse		**Work Phone**	
Email Address			

	Race*	Hispanic Ethnicity? (if applicable)*	Language Preference*
Info			

** Federal Guidelines now require medical practices to collect information regarding race, Hispanic ethnicity and Language preferences to help fight discrimination.*

Referring Physician		**Referring Patient**	
Primary Physician		**How did you hear about us?**	

	PRIMARY Health Ins Company	Policy Number	Group Number
Info			
	Insured Party (Policy Holder)	**Insured Party D.O.B.**	**Patient's Relationship to Insured Party**
Info			

	SECONDARY Health Ins Company	Policy Number	Group Number
Info			
	Insured Party (Policy Holder)	**Insured Party D.O.B.**	**Patient's Relationship to Insured Party**
Info			

Primary Insurance Copay		**Referral Begin Date**	
Secondary Insurance Copay		**Referral End Date**	
REFERRAL Auth Number		**# of Visits Authorized**	

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Receipt of Notice of Private Practices (HIPAA)

I have received, read and agree with the Notice of Privacy Practices and the Office and Financial Policies.

☐ I don't want anyone else to receive my medical information.

☐ I give consent to release all of my past, present and future medical information to the below listed names:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

☐ **I agree to receiving confirmations through text messaging.**

Primary Care Physician: _____

Emergency Contact Information

Name:_____ Relationship:_____

Telephone: (_____) _____ - _____

Patient Signature:_____ Date: _____

Patient Name (Printed):_____

Patient E-MAIL: _____

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1447 York Road | Suite 301 | Lutherville | MD 21093 | 410.252.9090 | 410.494.7064 fax

OFFICE POLICIES

Updated November 2017

These policies may change without notice. Please call the office for updated information or if you have questions.

1. **24-hour Notice**: If an appointment must be cancelled or rescheduled, the patient must call the office at least **24 hours** in advance. Missed Dermatology appointments may result in a **$50** fee and missed surgical appointments may result in a **$75** fee.
2. **Late Arrivals**: If a patient arrives more than **15 minutes** after the scheduled appointment time, the appointment may need to be rescheduled. Please call the office if you believe that you will not arrive in time for your appointment.
3. **New Patient Demographics**: It is the patient's responsibility to notify the office of any changes, including insurance information, phone number and address.
4. **Referrals**: If an insurance policy requires the patient to obtain a referral, it will be the patient's responsibility to do so. Please note that follow-up visits are considered separate visits and may require a separate referral. If you do not have a valid referral, you must reschedule your appointment. If you choose to be seen we will not submit your claim to your insurer and you will be held financially responsible for the full amount.

FINANCIAL POLICIES

Updated November 2017

1. **Payment Policy**: Copayments and account balances must be paid at the time of service. If you are experiencing financial hardship and are unable to pay your balance in full, please contact the billing department for payment arrangements. Accounts that remain past due for **120 days** will be turned over to a collection agency unless payment arrangements are made. Accounts turned over to a collection agency will be charged a **$30** collection fee and be reported to the credit bureau.
2. **Cosmetic Policy**: Payment for cosmetic procedures and products will be collected in full at the time of service unless other arrangements are made prior to receiving the services. Cosmetic procedures and products will not be billed to your insurance company. If you believe that your insurance company will pay for cosmetic services, the office will provide you with any necessary documentation that may help you receive reimbursement. Requesting reimbursement for cosmetic services is the responsibility of the patient. Cosmetic products are non-refundable and non-returnable.
3. **Self-Pay Discounts**: Patients who do not have insurance coverage will be given a self-pay discount. Office visits will cost **$150** for new patients and **$75** for established patients. Prices for procedures vary and will be quoted at the time of service. Additional discounts may be applied at the discretion of the doctor. If lab services such as biopsies and/or bloodwork, are required, you will receive a separate bill from the lab. Questions regarding your lab bills must be directed to the lab.
4. **Insurance Discounts**: Patients with insurance coverage will be given the insurance company's discounted rate (also called the allowed amount). Any deductible, coinsurance, or copayment amount will not be discounted as this is the amount that the insurance company requires the patients to pay. Any copay, deductible or coinsurance is due at the time of service. If you believe you have been billed an incorrect amount, you may contact the billing department or your insurance company to discuss appeal options.
5. **Insurance Payment Denials**: If your insurance company denies payment of your visit for *any reason,* including failure to obtain a referral, you will be held responsible for the balance due. Payment arrangements may be made by contacting the billing department.

I, _____, agree to the above Office and Financial Policies.

Signature: _____ **Date:** _____

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Statement of Policy Regarding Credit Card Information

To Our Valued Patients:

Thank you for choosing Skin Care Specialty Physicians for your health care needs. We are happy to bill your health insurance company for the medical services that you receive in our office. However, various insurance plans pay differently, sometimes resulting in a balance which is due from you. For this reason, we will keep your credit card information on file to make it easy for you to pay any balances that may occur. This policy will benefit you in the following ways:

- Save you the expense of checks and postage
- Provide you with a convenient method of payment
- Keep the cost of your health care down
- Refunds if applicable after insurance adjustments

We will contact you prior to processing any credit card payment over $100.00.

Please fill in the requested information on the lines provided below:

_____

Cardholder Name:

_____

Patient Name:

I have read the above and understand that all account balances which I incur at Skin Care Specialty Physicians are ultimately my responsibility. I authorize Skin Care Specialty Physicians to process payments for balances on my account using the credit card information which I have provided.

_____

Signature of Cardholder Date

☐ **Check this box if you do NOT wish to authorize your credit card for balances.**

_____

Patient name (please print) Date