SCSPHYSICIANS skin care specialty physicians
MOHS & SKIN SURGERY CENTER

1447 York Road
Suite 301
Lutherville, Maryland 21093
Phone: 410-252-9090 Fax: 410-494-7064

Please *CAREFULLY REVIEW* all of your information below and *CORRECT OR FILL OUT* any missing areas.

ID #		**Address**		
Last Name		**City**		
First Name		**State & Zip**		
Birthdate		**Cell Phone**		
Email		**Home Phone**		
Age		**Marital Status**		
Hipaa Contact Name & Relationship		**Race**	**Ethnicity:**	**Language:**

PLEASE LET US KNOW IF YOU ARE INTERESTED IN COSMETICS **YES or N O**

	EMERGENCY CONTACT		
NAME			
NUMBER			
RELATIONSHIP			
REFERRING PHYSICIAN		**PRIMARY PHYSICIAN**	

	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			

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

Patient Signature: _____ Date: _____

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

1407 York Road | Suite 100A | Lutherville | MD 21093 | 410.252.9090 | 410.494.7064 fax

Office Policies (Updated JULY 2026)

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

A 3% processing fee will be applied to payments made by credit card: Payments made by debit card, HSA/FSA card, cash, or check are not subject to the 3% processing fee. Medicare patients will not be charged a processing fee, as required by law. If you are a Medicare patient, please contact our office to make your payment.

48 HOUR NOTICE REQUIRED FOR CANCELLATION: If an appointment must be cancelled or rescheduled, the patient is required to provide at least 48 hours' notice. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

FEE & PENALTY FOR LESS THAN 48 HOUR NOTICE: Failure to do so will result in a $50 (FIFTY DOLLARS) fee for each missed appointment. If this is a Surgical or a Cosmetic appointment without at least a 48 hours' notice it will result in a $100 (ONE HUNDRED DOLLARS) fees. This fee is not covered by insurance and must be paid prior to scheduling your next appointment. Excessive no shows/same day cancelations could result in dismissal from the practice.

LATE ARRIVALS: If a patient arrives more than 15 minutes after the scheduled appointment time, the appointment may need to be rescheduled and may result in a NO SHOW fee. Please call the office if you believe that you will not arrive in time for your appointment.

OFFICE CODE OF CONDUCT: Disrespectful or derogatory language or conduct on the part of either physicians, staff or patients can undermine trust and compromise the integrity of the patient-physician relationship. This can result in an immediate dismissal from our practice.

PATIENT IS RESPONSIBLE FOR THE INFORMATION WE HAVE: It is the patient's responsibility to notify the office of any changes, including insurance information, phone number, address, and email.

PATIENT RESPONSIBILITY FOR 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.

APPOINTMENT RESCHEDULING REQUIRED IF REFERRAL NOT VALID: 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 at the time of the visit.

Financial Policies (Updated JUNE 2026)

PAYMENT AT TIME OF SERVICE: Copayments and account balances must be paid at the time of service.

CREDIT POLICY: Any credit on patient accounts will be applied to future visits or refunded per patients request.

LAB SERVICES: 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.

FINANCIAL HARDSHIP ARRANGEMENTS: 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.

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COLLECTION AGENCY FEES: Accounts turned over to a collection agency will be charged a $30 collection fee and be reported to the credit bureau. There will be a $50 fee for all returned checks.
DISPUTING A CREDIT CARD PAYMENT: If you dispute your credit card payment to our office you will be charged a $25 fee.
PAYMENT FOR COSMETIC PROCEDURES: Payment for cosmetic consultations, services and products will be collected in full at the time of service. Cosmetic procedures and products will not be billed to your insurance company. Cosmetic consultations, services and products are non-refundable and non-returnable.
INSURANCE PAYMENT FOR COSMETIC PROCEDURES: 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.
SELF PAY POLICY: Patients who do not have insurance coverage will be required to pay for their visit prior to seeing the Clinician. Fees for office visits & procedures performed will vary & will be quoted at the time of service at the discretion of our Clinicians. These charges must be paid at the time of visit.
SELF PAY FOR OUTSIDE LAB SERVICES: 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.
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.
PATIENT RESPONSIBILITY FOR ACCURATE INSURANCE INFORMATION: It's your responsibility as a patient to provide our office with your current up to date insurance information. Failure to do so could result in the full balance owed as your responsibility.
FORMS COMPLETION POLICY: FMLA, Short- & Long-Term Disability forms, Aflac, and any additional forms that need to be completed; there will be a $30 fee per form for completion. We will complete the form and fax it to the designated recipient (or return it to you if you prefer) within 3 business days of receipt of payment. This cannot be billed to your insurance company.

***SIGNATURE: I have read and agree with the notice of the Abridged Privacy Practices (HIPAA) and the above Office and Financial Policies for Skin Care Specialty Physicians. A complete copy of either form is available on our website; www.scsphysicians.com, or in the office. I have read the above and understand that all account balances which I incur at Skin Care Specialty Physicians are ultimately my responsibility.

Patient Acknowledgement

Please check the applicable boxes and enter your name in the signature box below:

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

I consent to receiving text messages from Skin Care Specialty Physicians regarding appointment reminders and confirmations, billing and financial notifications, and other communications related to my care. Standard message and data rates may apply. Message frequency may vary. _____

I have read the above and understand that all account balances which I incur at Skin Care Specialty Physicians are ultimately my responsibility. _____

I have read and agree with the notice of the Abridged Privacy Practices (HIPAA) and the above Office & Financial Policies for Skin Care Specialty Physicians. A complete copy of either form is available on our website www.scsphysicians.com or in the office.

I _____ agree to the above Office & Financial Policy.
print name

Email: _____

Signature: _____ DATE: _____

FRONT DESK FORMS

Abridged Notice of Privacy Practices - Please read through

A. OUR COMMITMENT TO YOUR PRIVACY

We will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. Our practice will always post a copy of our current Notice of Privacy Practices in our offices in a visible location, and you may request a full version paper copy of our most recent Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI: Treatment, Payment, Health Care Operations, Appointment Reminders, Treatment Options, Health-Related Benefits and Services, Release of Information to Family/Friends, Disclosures Required by Law

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of: Public Health Risks, Health Oversight Activities, Lawsuits and Similar Proceedings, Law Enforcement, Deceased Patients, Organ and Tissue Donation, Research, Serious Threats to Health or Safety, Military, National Security, National Security, Inmates, Workers' Compensation

D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you: Confidential Communications, Requesting Restrictions, Inspection and Copies, Amendment., Accounting of Disclosures, Right to a Paper Copy of This Notice, Right to File a Complaint, Right to Provide an Authorization for Other Uses and Disclosures

If you have questions regarding this notice or our health information privacy policies, please contact:

SKIN CARE SPECIALTY PHYSICIANS
HIPAA Security Officer
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Lutherville, MD 21093
(410) 252 9090