



Patient Demographics

First Name: _____ MI: _____ Last Name: _____ Date: _____

Mailing Address: _____ City: _____ State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Social Security Number: _____ Marital Status: _____

Email Address: _____

Home Number: _____ Cell Number: _____ Work Number: _____

*****Please circle the preferred number to contact you*****

I give permission to leave a voicemail message with medical information or test results: Yes No

Name of Employer: _____ Occupation: _____

Primary Care Physician: _____ Referring Physician: _____

HIPPA Release

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

I give permission for my medical information or test results to be released to (Ex: Spouse/ Child):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Local Preferred Pharmacy

Name: _____

Street: _____

City or Zip Code: _____

Insurance Information

Responsible Party: Self Spouse Parent/Guardian

If other than self, Name: _____ Date of Birth: _____

Primary Insurance (Leave Blank if you have your card)

Insurance Company: _____ Member ID: _____ Group #: _____

Secondary Insurance (Leave Blank if you have your card)

Insurance Company: _____ Member ID: _____ Group #: _____



Patient Demographics

Office Financial Policies

We are committed to providing the best treatment possible for our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns. For your convenience we accept credit cards, personal checks, and cash.

COST ESTIMATES: Although our fees are customary for our area, our assistants may only be able to give you a cost range over the phone. A consultation and diagnosis by the provider may be necessary to determine which procedure is best for you.

INSURANCE: Please refer to the list of insurance companies that we participate with. If you are not insured with one of these companies, we will gladly file your claim; however, you are responsible for payment in full at the time of service. If we do participate in your plan, but you do not have a current insurance card at your visit, full payment will be required until we can verify your eligibility. Please contact your insurance company if you have any questions regarding your coverage prior to your visit. **I hereby authorize and direct my insurance carrier to pay directly to Bluewater Dermatology and Skin Cancer Center, PA all insurance benefits, if any, due to me under my insurance plan. I further agree to pay the balance of the charges not paid by my insurance. I hereby authorize the release of any necessary information to secure payment of benefits.**

CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE: All co-payments and deductibles must be paid at the time of service. **Some plans require only your co-payment amount for office visits but have a deductible or co-insurance percentage that applies to any procedures performed in the office (e.g., biopsies, freezing of warts or pre-cancerous lesions, acne surgery, removal of lesions, and other office procedures).** Only your insurance plan can verify that information for you. The guardian that escorts a minor to the office will be responsible for copayment, deductible and coinsurance amounts at the time of service.

NON-COVERED OR COSMETIC SERVICES: Some services that we provide (e.g., acne surgery, cyst injections, keloid scar injections, removal of benign lesions, or skin tags) may be considered “not medically necessary” by your insurance carrier. You will be responsible for payment in full if your plan considers your visit as a non-covered service. The following cosmetic procedures are not covered by insurance and must be paid at the time of service such as: Botox or Dermal fillers, (e.g. Juvéderm, Radiesse).

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the provider. We will also obtain a copy of your driver’s license or picture ID and a current valid insurance card. If you fail to provide us with the correct insurance information or any insurance changes when they occur, you will be responsible for the charges denied by the insurance plan.

NONPAYMENT: In the event an account balance that has been determined to be your responsibility remains unpaid, a Third-Party Agency will be given permission to pursue recovery of the unpaid amount and any charges relating to the collection of that owed amount. The office will not be available to you for any non-emergency care until the amount due has been paid.

MEDICARE: We are Medicare participating providers and will gladly file your Medicare and Medigap claims. You will be responsible for any annual deductible determined by your plan or for any non-covered or cosmetic charges. If no payment is received from your secondary plan within 60 days after we file a claim, you will be responsible for the balance.

MISSED APPOINTMENTS: Our office policy is to charge \$25.00 for missed appointments not canceled within 24 hours.

RETURNED CHECK FEE: There is a \$25.00 fee for checks returned by the bank for non-sufficient funds. Payment of the returned check amount and fee is required within 14 days of notification to avoid further collection actions.

Privacy Policy: I have been offered a Notice of Privacy Practices for Bluewater Dermatology and Skin Cancer Center, PA as required by the Health Insurance Portability and Accountability Act of 1996.

Your signature below signifies that you understand our financial policies and your responsibility regarding charges incurred in this office.

Patient Signature: _____ Print Name: _____ Date: ____/____/____
(or Legal Representative)