PREMIER DERMATOLOGY PARTNERS

Patient Information Sheet

Please fill out the entire form. If a question does not pertain to you please write N/A (non-applicable).

Last Name ______________________ First Name ______________________ Patient ID # ________________

DOB __________ Sex M / F SS# ________________ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ ________________

Phone:
Home # ______________________ Cell # ______________________ Work # ________________

How do you wish to receive reminders? (You can select more than one)
Email ______________________________ ☐ Phone ☐ Email ☐ Mail ☐ Text

Florida Address ______________________________ City ______________ State ________ Zip ________

Alternate Address ______________________________ City ______________ State ________ Zip ________

Employer ______________________________ Employer Phone # ________________

PCP (Primary Care Doctor) ______________________________ City, State ________________

Which doctor referred you here? ______________________________ City, State ________________

Pharmacy ______________ City and cross streets ______________ Pharmacy Phone # ________

Where did you hear about us: ☐ Radio ☐ TV ☐ Internet ☐ Paper ☐ ________________

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

If Race, Ethnicity, or Language is incorrect please correct below:

Race: ______________________

☐ American Indian/Alaska Native
☐ Nat. Hawaiian/Pacific Islander
☐ Asian
☐ Other Race ______________
☐ Black/African American
☐ White
☐ Declined

Ethnicity: ______________________

☐ Declined
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Primary Language: ______________________________

Do you understand English? ☐ Yes ☐ No

Do you need communication/translation assistance? ☐ Yes ☐ No

Insurance Information

Insurance company plan ______________ City ______________ State ________ Zip ________

Subscriber: self / spouse name ______________________________

SS# ____________ Relationship to Subscriber ____________ DOB ____________ Phone # ________

Subscriber's Address ______________ City ______________ State ________ Zip ________

Secondary Ins. ______________ Policy # ______________ Group # ________

Ins. Address ______________ City ______________ State ________ Zip ________

Subscriber ______________ Relationship ______________ DOB ________

Subscriber's Address ______________ City ______________ State ________ Zip ________

Is this a work related injury? Y / N Is this related to an auto accident? Y / N

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PREMIER DERMATOLOGY PARTNERS®

Financial & Office Policies

Thank you for choosing us as your healthcare provider. We care about our patient's physical and financial well being and welcome the opportunity to work with you on any billing issue that may arise. We have implemented a new financial and office policy stating our expectations and options for payment.

I assign all medical and / or surgery benefits, to include "major medical" benefits, which I am entitled inclusive of Medicare and all other health payments this association is entitled. Payment is due at the time services are provided unless other plan(s) have been set up. I understand you do not accept assignment in the case of liability actions.

Insurance Billing
Though Premier Dermatology Partners® accepts most insurance plans, I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Insurance Referrals
If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

Self Pay
If I am un-insured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

Patient Billing
I understand that I will be sent a single monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. **If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collections agency. I will be responsible for any reasonable cost of collection including credit checks, court costs and attorney's fees.** If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements. I understand that if my check is returned, I will be charged a fee of $50.00

I authorize the release of medical record information to: 1) the above named insurance companies, 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

Co-payments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any services provided by Premier Dermatology Partners®. I understand that I am financially responsible for payment of any services rendered to me by Premier Dermatology Partners®. I have read and accept the terms of this policy.

Signature ______________________ **Date** ______________