DSCS Patient Registration **DATE**_____

Patient Registration Information

PATIENT _____Age _____Date of Birth _____

Mailing Address _____ SSN _____ M or F

_____ Home Phone _____

Physical Address _____

Cell Phone _____ email: _____

Employer_____ Occupation _____
Work Work
Address _____ Phone _____

SPOUSE _____ Date of Birth _____

Employer _____ Social Security No. _____
Work Work
Address _____ Phone _____
Relationship to
GUARANTOR _____ **Patient** _____

EMERGENCY CONTACT:_____ **Phone #** _____

****

PRIMARY INSURANCE _____ Subscriber Number _____

Subscriber _____ Date of Birth _____

SECONDARY INSURANCE _____ Subscriber Number _____

Subscriber _____ Date of Birth _____

****

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT, AND AGREEMENT TO PAY FOR SERVICES

I hereby authorize **DSCS** to release any information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of **LIFETIME**. I claim any insurance benefits due me for services rendered by **DSCS** and authorize and direct my carrier to issue payment check(s) directly to **DSCS.** Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

_____ _____

Patient Signature **DATE**

Dermatology and Skin Cancer Specialists, PSC

FINANCIAL POLICY

Thank you for choosing DSCS for our dermatological care. Your health is our greatest priority. Of course, as with any business, we must reconcile our financial relationship as well. Patients have access to a variety of health care plans, and our financial relationship is dictated primarily by the health plans that you, the patient, choose. Many of you have selected plans that have co-payments and deductible, and it is our responsibility to collect those fees ***at the time of each visit*** to our office. Our contract with your insurance carrier REQUIRES us to make these collections. We appreciate your cooperation with our staff in this regard. If you have questions about this process, please contact your insurance company.

Payment

Payment in full is due at time of service. Co-payments will be collected at the time you check in the office. Patients who have not met their deductible will need to satisfy that amount before treatment is rendered. Co-insurance due for extensive care will be determined when benefits are verified and that co-insurance amount will also be due at the time of service.

Insurance

We file your insurance claim as a courtesy. Ultimately, expenses incurred are the responsibility of the patient. Should your insurance company deny your claim or not respond to our collection efforts, payment will be expected from the patient.

Unpaid Balances

A fee of $50 will be assessed on any check returned or otherwise not honored by your bank. This fee is due IN CASH CURRENCY when you come to the office to retrieve the original check.

Collection Accounts

In the event that my account is released to a collection agency, I agree to pay all collections costs, court cost and attorney's fees incurred to collect my account.

Missed Appointment Policy

We ask that you cancel or reschedule appointments with a 24 hour advance notice. Failure to notify the office of cancellation will result in a $25 charge to your account. If you arrive more than 15 minutes late for your appointment, we will ask you to reschedule in consideration of our other patients.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Dermatology and Skin Cancer Specialists, PSC

FINANCIAL POLICY

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Returned Checks: A fee of $50 will be assessed on any check returned or otherwise not honored by your bank. This fee is due IN CASH CURRENCY when you come to the office to retrieve the original check.

Insurance: We file your insurance claim as a courtesy. Ultimately, expenses incurred are the responsibility of the patient. Should your insurance company deny your claim or not respond to our collection efforts, payment will be expected from the patient.

Unpaid Balances: You will receive an Explanation of Benefits from your insurance carrier which shows the amount owed after the claim is processed. Our billing office will send TWO statements for this amount. If the amount due is not paid, the account will be released to the collection agency.

Collection Accounts: In the event that my account is released to a collection agency, I agree to pay all collections costs, court cost and attorney's fees incurred to collect my account.

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I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Consent for the Use or Disclosure of Protected Health Information

Dermatology and Skin Cancer Specialists, PSC
161 N. Eagle Creek, Suite 150
Lexington, KY 40509

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

_____ _____
Signature Date

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

_____

_____

_____

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this consent.

_____ _____
Signature Date