PATIENT INFORMATION - PLEASE PRINT

Today's Date ___/___/___

Name ______________________________
Last First M.I.

Mailing Address ______________________________
City State Zip

Home Phone ____________ *Work Phone* ____________ *Cell Phone* ____________
Area Code Area Code Area Code

Date of Birth ___/___/___ *Age* ___ *Sex* ___ *Marital Status* ___ *Occupation* ________ *SS #* ________

Referred by: ___ Family ___ Yellow Pages ___ Insurance Co. Pharmacy ______________

Primary Care Physician ______________ / ______________

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name ______________________________
Last *First* *M.I.*

Address ______________________________
City *State* *Zip*

Home Phone ____________ Work Phone ____________ SS# ____________
Area Code *Area Code*

Date of Birth ___/___/___ Sex ______

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name ______________

Ins. Address ______________

Name of Insured ______________

Insured's ID# ______________

Group# ______________

Employer Name ______________

Employer Address ______________

Employer Phone ______________
Area Code

Relationship of patient to the Insured ______________

FOR MEDICARE PART B: **HAVE YOU RECENTLY JOINED A MEDICARE HMO?** **YES** ___ **NO** ___

I request that payment of authorized Medicare benefits be made to BAY RIDGE SKIN & CANCER for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and **THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON COVERED SERVICES.** Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDICARE Beneficiary Signature ______________________________

FOR ALL OTHER INSURANCE:

I understand that it is my responsiblity to have proper authorization for **every visit** at BAY RIDGE SKIN & CANCER, DERMATOLOGY. **Applicable co-payments apply to each visit.**

In the event my referral is invalid due to **expired date,** or **terminated coverage I understand I will be responsible for FULL payment for services rendered.**

For "Out of Network", "Freedom", "PPO" and/or non participating plans **I understand that deductibles and coinsurance (in addition to co-payment)** may apply according to the terms of my contract **and I will be billed for any amount my insurance company determines to be my responsibility.**

PATIENT SIGNATURE* ______________________________
*(Under 18, parent or guardian must sign above)

I acknowledge that I have received a copy of Bay Ridge Skin & Cancer Dermatology P.C.'s "Notice of Privacy Practices".

______________________________ ______________
Signature of Patient Date
(Under 18 parent/guardian must sign)