Genesis Dermatology

Date: _____ Referred by: _____

Name: _____
(Last) (Middle Initial) (First)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ S.S. Number_____

E-Mail Address: _____

2nd Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Emergency Contact: _____
(Name) (Phone)

MEDICARE and CIGNA ARE WITHIN NETWORK ALL OTHER INSURANCES ARE CONSIDERED OUT OF NETWORK

Patients with insurance plans with which we participate are responsible for appropriate co-pays, co-insurance, and deductibles at the time of service. Not all services are a covered benefit in all contracts. If your insurance company denies any procedure as a "non-covered service", you will be responsible for these services. If we do not participate with your insurance and you have paid for your visit, as a courtesy, we will submit the claim to your insurance company. Reimbursement is based on each individual's out of networks benefits. If eligible, your insurance should reimburse you directly. If Genesis happens to receive the reimbursement payment you will be refunded accordingly. We understand temporary financial problems may affect timely payment on your account. We are here to help you and encourage you to contact us promptly for assistance in the management of your account should the need arise. Patient acknowledges that a 29% collection fee and any additional legal fees that accrue from efforts necessary to resolve an unpaid balance will be assessed, and are the responsibility of the patient (parent or guardian in the case of minor status at the time of visit). A $25 fee will be incurred for any returned checks.

_____ _____
Signature Date

Your signature signifies your understanding and agreement with our policies.

Genesis Dermatology

Acknowledgement of Receipt of Notice of Privacy Practices

Genesis Dermatology reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have received a copy of the Notice of Privacy Practices for Genesis Dermatology.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Patient Representative to Patient

Receipt of Notice of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

[ ] The patient was undergoing emergency treatment
[ ] The patient declined to sign the acknowledgement
[ ] Other_____

SIGNATURE

Name of Patient (Print or Type)

Name of Staff Member

Date

Genesis Dermatology

PHARMACY INFORMATION

By supplying the below information we are striving our best to make your prescription an easy process by having your script available to you as soon as possible. Without complete information below, we may not be able to submit your prescription electronically and may need to give you a hard copy to take manually to the drug store.

PHARMACY NAME:_____

PHONE #:_____

ADDRESS:_____
Number Street Name Zip

PATIENT NAME:_____

OFFICE USE ONLY: Information available: YES_____ NO_____

Insurance Information

Policy Holders Name: _____

Policy Holder Date of Birth: _____

Policy Holder SS#: _____

Patients Name:_____

Relation to policy holder:_____

Genesis Dermatology

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This is an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will still be due at check-out.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,
Genesis Dermatology

I authorize Genesis Dermatology to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express

Account Number_____ Exp. Date_____

Name on Card (please print)_____

Signature_____ Date_____

***Should you decline this form please put an X through the page.