Lake DERMATOLOGY, INC.

This form will need to be updated yearly.

Patient Information: **Chart #:_____**

Name:_____ Nicknames: _____

Address:_____City: _____State:_____Zip:_____

Mailing Address (if different):_____

Phone Number: _____Date of Birth:_____Age:_____

Cell Phone Number: _____Place of Employment: _____

Gender:____ Male____Female **Work Phone: _____**

Preferred Spoken Language:	**Race:**	**Ethnic Group:**
__English **__Other (please specify)_____**	**__White** **__American Indian or Alaskan Native** **__Asian** **__Black or African American** **__Native Hawaiian or other Pacific Islander**	**__Hispanic or Latino** **__Non Hispanic or Latino** **__Unknown**

Primary Health Professional:_____Title (circle one): MD DO NP PA
Office Address: _____

Referring Health Professional:_____Title (circle one): MD DO NP PA
Office Address: _____

Social Security Number: _____

Insurance:
Primary:_____

Subscriber Name:_____

Subscriber DOB:_____

Insurance:
Secondary:_____

Subscriber Name:_____

Subscriber DOB:_____

Responsible Party (FOR MINORS ONLY):
Name:_____ Relationship: _____

Address:_____City: _____State: _____Zip:_____

Telephone: _____Social Security Number: _____Date of birth:_____

Emergency Contact Information:
Name: _____Relationship:_____

Phone Number:_____

My signature below indicates that all of the above information is accurate.

_____ _____

Signature **Date**

Please fill out front and back.

Continue →

FINANCIAL POLICY

Thank you for choosing Lake Dermatology, Inc. for your dermatology health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with us.

We do require all patients to complete their registration information, read and sign our financial policy prior to receiving your examination or treatment.

Commercial Insurance: Any deductible/ copayment or 20% of services will be paid each visit. After insurance has paid, any remaining balance will be the responsibility of the patient, due within 10 days.
In the event that you, as the patient, or we, as the physician, are not aware of a charge that is not covered by your plan, you will be billed after we obtain a denial from your insurance carrier payment due within 10 days.

Self-Pay: 100% of services rendered each visit.

Payments can be made by cash, check, debit or credit card. In the event of a returned check, a $35.00 service fee will be charged to your account.
After three statements and no payment is made delinquent accounts will be turned over to collections. If your account goes to collections, you agree to be responsible for all fees involved in the collection process.

I hereby guarantee payment of all charges incurred at Lake Dermatology, Inc. I hereby assign and direct to pay any and all benefits for medical services under this claim to Lake Dermatology, Inc. I authorize the release of any medical information necessary to process my claim with the above assignment.

Responsible Party Signature:_____ **Date**:_____

MEDICARE

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/ Supplemental carries. However, in the event that the secondary does not pay within 60 days, patients will be billed.

I authorized assignment of Medicare benefits to Lake Dermatology, Inc. for any services furnished by that physician/provider. I authorize the holder of Medicare information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services. I understand my signature authorizes release of medical information necessary to pay the claim If "the other health insurance" is indicated in box 9 of the HCFA 1500 form, or elsewhere on the approved claim forms or electronically submitted claims, 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.

Responsible Party Signature:_____ **Date**:_____

CANCELATION/NO SHOW POLICY

Lake Dermatology Inc. requires 24 hours notice for any canceled appointments. We reserve the right to charge a failed visit fee of $25 for any office visit/ $50 for any procedure not canceled within 24 hours, but will take cases of emergency into consideration.

Responsible Party Signature:_____ **Date**:_____