New Patient Updated Information **SkinCare Physicians & Surgeons**

Patient's Legal Name _____ Date of Birth _____ Sex Male or Female

Parent Name of Minor Child _____ Patient's Social Security # _____

Driver's License # _____ Employer _____ Occupation _____

Home Address _____ City _____ Zip Code _____

Mailing Address if different _____ City _____ Zip Code _____

Email Address _____ Name of Spouse _____

Home Phone # ( ) _____ Ok to leave message Yes No Cell Phone # ( ) _____ Ok to leave message Yes No Work # ( ) _____ Ok to leave message Yes No

Who to notify in case of emergency _____ Relationship _____ Phone # _____

Alternate Phone # _____ How did you hear about our practice? _____

Whom may we thank for referring you to our practice? _____

Insurance Information SkinCare Physicians & Surgeons are NOT participating providers in HMO's, Managed Care Plans and some PPO Plans. Respectfully, it is your responsibility to know what your benefit coverage is and whether the providers at SCPS are 'in network' or 'out of network' providers. We do NOT contract with all PPO's. We may bill your insurance as a courtesy if we are not participating providers, however, you are financially responsible for all services. Pathology and Laboratory fees are billed separately by the processing entities.

Subscriber/Guarantors Legal Name _____ Relation to Patient _____

Insurance Company Name _____ Insurance ID # _____

Please read and sign all statements; if you have any questions please ask.

Permission for Treatment

Permission is hereby granted for physicians, medical residents, employees or agents of SkinCare Physicians & Surgeons to render medical and or surgical treatment as deemed necessary.

Signature of Patient or Parent of Minor Child _____ **Date** _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes SkinCare Physicians & Surgeons to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each claim to be submitted for myself or dependents and that I will be bound by this signature as though the undersigned had personally signed the individual claim. I hereby authorize my insurance company to pay and hereby assign directly to SkinCare Physicians & Surgeons, all benefits if any, otherwise payable to me for services as described when received by and paid to SkinCare Physicians & Surgeons. I acknowledge that it is my responsibility to know what my benefits are and whether or not SkinCare Physicians & Surgeons are preferred providers with my insurance plan or are out of network providers. I am aware that SCPS may bill my insurance plan as a courtesy and that I will be financially responsible for all deductibles, coinsurance, out of network charges that have been incurred.

Authorized Signature of Subscriber _____ **Date** _____

Financial Agreement

I understand that I am financially responsible for all charges incurred. I understand that SkinCare Physicians & Surgeons is not contracted with any HMO or Managed Care plans and that I am financially responsible for payment in full for all services rendered. Payment for cosmetic and non-covered services, copays and deductibles is due in full at the time of service. A 25% deposit is required to hold a surgical appointment. The deposit will be applied to your procedure. If you cancel the surgery/treatment within five working days of the scheduled surgical procedure the 25% deposit is nonrefundable. I understand that cosmetic consultations are $100. I understand that if within two months of my cosmetic consultation I obtain cosmetic services I may receive a $100 credit toward a cosmetic treatment. I understand that if I do not cancel or reschedule an office appointment/procedure within 48 hours of the appointment I will be charged for the missed appointment. I am aware that SCPS may bill my insurance plan as a courtesy and that I will be financially responsible for all deductibles, coinsurance and out of network charges that have been incurred. I know that SCPS does not have contracts with all PPO plans. Your signature below signifies that you have read and understand our financial policy. You agree to abide by the policy and fulfill your financial responsibility under this agreement.

Signature of Patient or Parent of Minor Child _____ **Date** _____