

SkinCare Physicians & Surgeons Registration Form

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|--|-------------------------------|--------------------------|---------------------------------|---------------------------------|-------------------------------|
| New Patient | Date | New Address information | New Insurance | Effective date of new insurance | |
| Patient's <u>Legal Name</u> | | Date of Birth | | Age | Sex |
| Parent Name of Minor Child | | | | | |
| Patient's Social Security Number | | | California Driver's License No. | | |
| Home Address | | City | State | Zip | Email Address |
| Mailing Address if Different | | City | State | Zip | |
| Home Phone No. () | Ok to Leave Message Yes No | Cell Phone No. () | Ok to Leave Message Yes No | Work Phone () | Ok to Leave Message Yes No |
| Your Occupation / Employer | | | | | |
| Employer's Address | | City | State | Zip | |
| Name of Spouse | | | Employer's Name | | |
| How Did You Hear About Our Practice? | | | | | |
| Whom May We Thank for Referring You to Our Practice? | | | | | |

NOTIFY IN CASE OF EMERGENCY

| | | | |
|------|--------------|-------------------------|------------------------------|
| Name | Relationship | Telephone No. () | Alternate Phone No () |
|------|--------------|-------------------------|------------------------------|

PLEASE COMPLETE ALL INSURANCE INFORMATION BELOW We are not participating providers in HMO's, Managed Care Plans and some PPO plans.

| | | | | | |
|---|---|-------------------------|-------|-----|--|
| Subscriber/Guarantors Legal Name | | Relationship to Patient | | | |
| Home Address (if not the same as patient) | | City | State | Zip | |
| Insurance Company Name | <small>SCPS is <u>not</u> contracted with any HMO or Managed Care Plans. 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 <u>do not</u> have contracts 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.</small> | | | | |
| Insurance Identification or Member Number | Group Identification Number | | | | |
| Office Copay \$ | <small>SkinCare Physicians & Surgeons is not contracted with any HMO or Managed Care Plans. Pathology lab fees are billed separately by the processing lab and pathology office</small> | | | | |
| Secondary Insurance Company Name | <small>SCPS is <u>not</u> contracted with any HMO or Managed Care Plans. SCPS is <u>not</u> contracted with all PPO plans.</small> | | | | |
| Insurance Identification or Member Number | Group Identification Number | | | | |

PLEASE READ AND SIGN ALL STATEMENTS

Permission for Treatment

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

Signature of Patient OF (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 within five working days of the scheduled surgical procedure the 25% deposit is non refundable. 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 OF (parent of minor child) _____ Date _____