

SKIN CANCER CENTER OF CENTRAL FLORIDA

PATIENT INFORMATION

Please Print Clearly

Date: _____

PATIENT NAME: _____ last _____ first _____ mi

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____

THE GOVERNMENT REQUIRES WE ASK THE FOLLOWING:

PHONE: HOME (_____) _____ - _____

PREFERRED LANGUAGE: _____

CELL (_____) _____ - _____

ETHNICITY: _____

WORK (_____) _____ - _____

RACE: _____

MALE FEMALE

OUT OF STATE ADDRESS: _____ PHONE: (_____) _____ - _____

CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: (circle one) M D W S SS # _____

EMERGENCY PHONE NO.: NAME: _____ NUMBER _____

SPOUSE'S NAME (if minor, PARENT'S) _____ SPOUSE'S DATE OF BIRTH: _____ / _____ / _____

PHARMACY: _____

ADDRESS: _____ PHONE: (_____) _____ - _____

PRIMARY PHYSICIAN NAME: _____

ARE YOU COVERED BY MEDICARE? yes no

DO YOU HAVE A SECONDARY TO MEDICARE? yes no

ARE YOU COVERED BY GROUP INSURANCE? yes no

I GIVE MY PERMISSION TO RELEASE MY MEDICAL AND BILLING TO THE FOLLOWING PERSONS:

1 _____ RELATIONSHIP _____

2 _____ RELATIONSHIP _____

SIGNATURE DATE _____

DATE _____

SKIN CANCER CENTER WITNESS

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

V. AGREEMENT TO BE TREATED - I, the below signed person, agree to be treated by Skin Cancer Center of Central Florida, and agree that I am responsible for payment of all services.

DATE _____ PATIENT _____ Signature

SUBSCRIBER (if different from patient) _____ Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

I hereby authorize Skin Cancer Center to release to any physician, hospital or medical care facility any information acquired in the course of my examination or treatment. I hereby authorize any physician, hospital, or medical care facility to provide all medical history to Skin Cancer Center.

This will enable us to provide the best patient care.

DATE _____ PATIENT _____ Signature

SUBSCRIBER (if different from patient) _____ Signature