

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## *Associates in Dermatology, Inc.*

Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: M F Marital Status: S M W D Race: Asian/Black/Hispanic/White/Other

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

E-Mail \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Medication Allergies** \_\_\_\_\_

Latex allergies Yes No

Parent/Guardian \_\_\_\_\_ Contact # \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Referring/Family Physician \_\_\_\_\_

### **Insurance Information**

Primary Insurance Carrier \_\_\_\_\_

Policy Holders Name \_\_\_\_\_

Policy Holders SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Policy Holders Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_

Policy Holders Name \_\_\_\_\_

Policy Holders SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Policy Holders Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Contact Information** (someone **NOT** living in the same residence)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

## *Associates in Dermatology, Inc.*

I request that payment of authorized insurance benefits be made either to me or on my behalf to Associates in Dermatology, Inc. ("AID"), for any services furnished me by the listed provider-employee of AID. I authorize any holder of medical information about me to release to any federal or commercial health insurance organizations any information needed to determine these benefits or the benefits payable for related services.

I understand by signing this form that I am requesting that insurance payments for services rendered to me be made directly to AID and that I am authorizing the release of my medical information to pay applicable claim(s). If "Other Health Insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claims forms, or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown. With certain insurers, the patient may be responsible only for the deductible, co-payment, co-insurance, or non-covered services. Co-insurance and the deductible are based upon the charge determination of the individual carrier.

The undersigned state they have read the materials provided patients, or had them read to them, and they understand payment is due when services are rendered. Upon default in making payment, the undersigned agree to pay all reasonable legal fees and costs of collection to the extent permitted by Virginia law. Each guarantor waives presentation of payment, notice of non-payment, protest and notice of protest and agrees to all extensions, renewals, or release, discharge or exchange of any party or collateral without notice. This note shall take effect as a sealed instrument and be enforced in accordance with the laws of the Commonwealth of Virginia. This agreement shall be binding upon and inure to the benefit of the parties, their successors, heirs, assigns and personal representatives.

I have read, understand and agree to the financial policy. I understand that any charges that are not covered by my insurance company, as well as applicable co-payments and deductibles, are my personal responsibility.

I acknowledge that I have been given the opportunity to receive/read a copy of Associates in Dermatology, Inc.'s Notice of Privacy Practices.

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Signature of Patient/Guardian

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Date

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Print Name

My information may be released to:

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Relationship to Patient