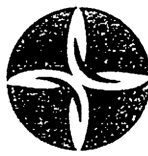

Dermatology
Surgical & Medical Group

PRIVATE PAY/COMMERCIAL/HMO REFERRAL INFORMATION

Patient Name:____________________Nickname: ____________________ Today's Date ____/____/____

Name of responsible party if patient is a minor (under 18) ____

Other family members that are patients ____

Referred by:________________________________Primary Care Physician ________________________

In case of Emergency, who should be notified?______________________ Phone (   )________________

RELEASE OF INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature __________________________________ Date ____/____/____

I authorize medical personnel to leave messages regarding my treatment plan and/or diagnosis on voicemail or answering machine, or with my spouse, caretaker or guardian, when I am not available by telephone.

Patient or Responsible Party Signature __________________________________ Date ____/____/____

PATIENT FINANCIAL POLICY

General Policy: We encourage you to inquire about our fees prior to the services being rendered by the physician so you can verify benefits with your insurance carrier. Since many insurance companies require the patient to pay a deductible, co-payment or percentage of the services rendered, it is important to determine the amount for which you will be responsible. **Co-payments are due at the time of service.** ______

Cosmetic Services: All cosmetic services, regardless of insurance coverage, are due and payable **in full** at the time of service. ______

HMO or other managed care patients: You are responsible for obtaining a referral from your primary care provider and ensuring that it has been obtained by this office prior to your visit. Per your insurance plan, the physicians will be unable to see you without the necessary referral. You will be responsible for paying your annual deductible, co-payment and charges for any non-covered services.

Dermatopathology: Occasionally we may send your biopsy out to an outside facility (UCSF, Stanford, etc.) for a second opinion. In this case, you will receive a separate bill from that laboratory (for example, UCSF or Stanford Dermatopathology). You will be responsible for both our bill and the other laboratory bill. ______

PPO Insurance Patients and Commercial Insurance Patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered services. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patients without insurance coverage: Charges are due at the time of service. Occasionally we may be unable to determine the exact charges before you leave the office, so we require a minimum deposit. You will be billed for the remainder of the charges when they are available at which point the remaining balance will be due.

Patient or Responsible Party Signature ________________________________ Date ____/____/____