

Westmoreland Dermatology & Surgery Center

Patient Information

Patient's Legal Name: (First, Middle, Last)		
SSN:	Date of Birth:	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Minor
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino	Race: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Other
Mailing Address (PO Box, City, State, Zip)		
Required Street Address (Street, City, State, Zip)		
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
<input type="checkbox"/> Yes, I would like to receive information, i.e., skin care information, specials, and upcoming events from Westmoreland Dermatology & Surgery Center and the CosMediCenter via email.		<input type="checkbox"/> No, I would not like to receive information via email.

Insurance Information Complete this information if the patient is covered under another individual's insurance plan

Name of Insured/Subscriber:		
SSN:	Date of Birth:	Relationship to Patient:
Mailing Address (PO Box, City, State, Zip)		
Required Street Address (Street, City, State, Zip)		
Home Phone:	Cell Phone:	Work Phone:

Guarantor Information Complete this information if the patient is under 21 ***Required***

Name of Parent/Legal Guardian:		
SSN:	Date of Birth:	Relationship to Patient:
Mailing Address (PO Box, City, State, Zip)		
Required Street Address (Street, City, State, Zip)		
Home Phone:	Cell Phone:	Work Phone:

As a patient, I hereby consent to the usual medical services while at Westmoreland Dermatology and Surgery Center.

Medicare and/or Medicaid: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by Westmoreland Dermatology, shall be made to the clinic and I specifically assign such benefits to the clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary are not authorized under the Medicare/Medicaid Program and I shall be responsible for the entire charges incurred unless other third party coverage is available.

Insurance: I hereby assign Westmoreland Dermatology and Surgery Center all rights, benefits, and interest under any insurance policy, health plan, or third party payer liable to me, in consideration for services rendered by the physician. I hereby authorize payment to Westmoreland Dermatology and Surgery Center by any insurance policy, health plan or third party payer for treatment received at the clinic. Secondary third payer insurance claims will not be filed by Westmoreland Dermatology and Surgery Center; however, we will provide you with the information needed for you to file and be reimbursed.

Financial Responsibility: I understand that I am financially responsible to the clinic for all charges not covered or paid by insurance. I also understand that my insurance will be filed as a courtesy, but I am financially responsible for any charges incurred at Westmoreland Dermatology and Surgery Center. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. We do verify benefits prior to your visit and do our best to provide an accurate estimate of "your portion" of the charges incurred that day. Charges remaining on an account after thirty days become the patient's responsibility. I also agree that in the case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all collection fees, finance charges, attorney fees, costs and other expenses will be paid by me. I understand that in certain circumstances, specimens may be sent to an outside facility for diagnostic purposes. I understand that I am responsible for any charges incurred.

Non-Certification: I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third party payer, I am responsible for assuring certification is obtained from the insurance company, third party administrator or health plan for the procedure date. If certification is not obtained, I further agree that in the event the insurance health plan or other third party payer denies either all or part of the payment on the account, I will pay the account in full upon demand from the clinic.

Consent for Release of Health Information for Billing and Payment Purposes: I consent to the release of my health information (medical records, medical results, and any and all other health information) by the clinic or any physician involved in my care for the purpose of billing, claims management, medical data processing, reimbursement, certification to any insurance company, third party payer, health plan or government agency which are necessary for the billing and payment of my account.

Photographs: I hereby give permission for the physicians of Westmoreland Dermatology or any assistant they may designate to take pictures for diagnostic purposes or for enhancement of the medical record.

New Regulations: State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. This notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided the law permits the changes. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and or received by us before the date changes were made.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. Health information about you may be disclosed to your family, friends, and/or other persons you choose to involve in your care. You may request a form to sign that prohibits anyone other than yourself having access to your health information.

Appointment Time _____

Westmoreland Dermatology & Surgery Center

Notice of Privacy Practices/Written Acknowledgement Form

I have reviewed a copy of Westmoreland Dermatology and Surgery Center's Notice of Privacy Policies.

Signature of Patient

Date

Treatment to Minors

This form must be completed if the patient is under the age of 21.

Many times parents find themselves unable to accompany their minor child to appointments. We require that this form be completed to insure that your child can receive medical treatment without your presence.

I authorize my child, _____, to receive medical treatment at Westmoreland Dermatology & Surgery Center.

I agree to pay any charges incurred. Our offices require payment at time of service and we accept all major credit cards. If your child is unaccompanied, please send one of these forms of payment.

Signature of Parent/Legal Guardian

Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ___/___/___

Release of Information

- I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

***** PLEASE FILL IN BLANKS WITH NAMES *****

Spouse: _____

Child(ren): _____

Other: _____

Any health care provider or facility: _____

Ok to leave a message: _____

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ___/___/___