PATIENT INFORMATION *(PLEASE PRINT)*

Office use only: Date ____________ Updated ____________ Patient MRN ____________

Name ____
Last *First* *MI*

Mailing Address ____
Street *City* *State* *Zip*

Home Phone ____________ Work Phone ____________ SS# ____________

Date of Birth ____________ Age ____________ Sex ____________ Marital Status ____________

Responsibile Party: *(if different from patient)*

Name ____
Last *First* *MI*

Mailing Address ____
Street *City* *State* *Zip*

Home Phone ____________ Work Phone ____________ SS# ____________

Pharmacy of Choice ______________________ Phone ____________

Emergency Contact ______________________ Phone ____________

Referred by ______________________ Phone ____________

Primary Care Physician ______________________ Phone ____________

Is there any physician other than your referring physician that you wish to have medical information sent to?

If so please list here: Name: ____________ Address: ____________

May we leave messages on your answering machine? **Yes** **No**

Insurance Information: *(Please present insurance card at the time of check-in)*

Primary Insurance Name ____________

Insurance Address ____________

Name of Insured ____________

Insured's Date of Birth __ / __/ __ Sex ____________

Insured's ID# ____________

Group # ____________

Employer Name ____________

Relationship of Patient to Insured ____________

Secondary Insurance Name ____________

Insurance Address ____________

Name of Insured ____________

Insured's Date of Birth __ / __/ __ Sex ____________

Insured's ID# ____________

Group # ____________

Employer Name ____________

Relationship of Patient to Insured ____________

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to precertify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

I have read and understand the above consent ___________(Initials)

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Maryland Skin Cancer Specialists, (MSCS), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to MSCS. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and MSCS.

I have read and understand the above assignment __________(Initials)

Authorization to Release Claims Information: I hereby authorize Maryland Skin Cancer Specialists, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize MSCS, its employees and agents to act on my behalf in completing claims.

I have read and understand the above release __________(Initials)

I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS AND ASSIGNMENTS PRINTED ON THE FRONT AND BACK OF THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

____

Patient's Printed Name

____

Signature of Patient *Date* *Witness*

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is described as follows:

____

Printed Name of Authorized Representative *Signature* *Date*

____

Relationship to Patient *Witness*