Fill Out and Bring to Appointment

Maryland Skin Cancer Specialists, PA
75 Thomas Johnson Drive, Suite H
Frederick, MD 21702
Phone: 301-668-9850

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 _____

Responsible 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 pre-certify 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*