

# LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, PC

NAME: \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SPOUSE'S/PARENT'S/GUARDIAN NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SEX: ( ) M ( ) F MARITAL STATUS: single married divorced widowed other

**MEDICAL EMERGENCY CONTACTS:** NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**REFERRED BY:** (Circle 1) DOCTOR / YELLOW PAGES / INS. PLAN / FRIEND / FAMILY / OTHER: \_\_\_\_\_

DR. OR FRIEND'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

FAMILY PHYSICIAN (OMIT IF ABOVE) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

## **HEALTH INSURANCE INFORMATION:**

## FINANCIAL POLICY:

PRIMARY INSURANCE NAME: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ INSURANCE ID# \_\_\_\_\_ SS# OF INSURED: \_\_\_\_\_

CERTIFICATE # \_\_\_\_\_ GROUP # \_\_\_\_\_ EMPLOYER/GROUP NAME: \_\_\_\_\_

2005/ 2006 / 2007 AMOUNT OF DEDUCTIBLE: \_\_\_\_\_ HAS THIS BEEN MET? YES / NO CO-PAY AMT \$ \_\_\_\_\_

## **SECONDARY INSURANCE NAME:**

NAME OF INSURED: \_\_\_\_\_ CO-PAY AMT \$ \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ INSURANCE ID# \_\_\_\_\_ SS# OF INSURED: \_\_\_\_\_

CERTIFICATE # \_\_\_\_\_ GROUP # \_\_\_\_\_ EMPLOYER/GROUP NAME: \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_ **LESION GROWING: SLOW FAST**

**WHERE ON THE BODY:** \_\_\_\_\_ **HOW LONG HAVE YOU HAD IT:** \_\_\_\_\_ (ie. days, months, years, don't know)

**MEDICAL HISTORY:** (PLEASE CIRCLE) BLOOD THINNERS (aspirin, vit. E, coumadin, plavix) PACEMAKER DEFIBRILLATOR PREGNANT IRREGULAR HEARTBEAT  
ABNORMAL BLEEDING PROSTHETICS ABNORMAL SCARRING NUMBNESS ASTHMA SKIN CANCER DIABETES SMOKING ALCOHOL DRUGS GLAUCOMA  
HIV/HEPATITIS HEART DISEASE LEAKY VALVES STROKE SEIZURES NERVE DAMAGE EXCESSIVE THIRST/URINATION DIZZINESS/FAINING COLD/HEAT  
INTOLERANCE HEADACHE HYPERTENSION LUNG DISEASE RECENT OPERATION/HOSPITALIZATION SWOLLEN GLANDS CHANGING MOLES  
DRY SKIN HIVES SKIN RASH/LESIONS WEAKNESS NIGHT SWEATS SUDDEN WEIGHT LOSS/GAIN FEVER: **NONE** (Please explain circled items)

**ALLERGIES?** \_\_\_\_\_ **NONE** **WHAT HAPPENS?** \_\_\_\_\_

**MEDICATIONS CURRENTLY TAKING?** \_\_\_\_\_ **NONE**

**FAMILY HISTORY OF:** (PLEASE CIRCLE) ATYPICAL MOLES MELANOMA SQUAMOUS CELL CARCINOMA BASAL CELL CARCINOMA **NONE**

(Please identify relationship to self) \_\_\_\_\_

## **PLEASE READ THIS STATEMENT AND SIGN BELOW:**

ALL INFORMATION I HAVE GIVEN IS TRUE AND COMPLETE. THIS SIGNATURE WILL ALSO BE USED AS "SIGNATURE ON FILE" FOR INSURANCE PURPOSES INCLUDING ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM. I GIVE PERMISSION FOR MEDICAL PHOTOGRAPHS TO BE TAKEN AND THEY MAY BE USED FOR EDUCATIONAL PURPOSES. (PLEASE CROSS OUT THE PREVIOUS SENTENCE IF NOT DESIRED). I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, P.C. I HAVE READ THE LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, PC. FINANCIAL POLICY AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

**X** SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**LONG ISLAND SKIN CANCER & DERMATOLOGIC SURGERY, P.C.**  
**FINANCIAL POLICY**

Thank you for selecting the Long Island Skin Cancer & Dermatologic surgery, P.C. for your dermatologic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information is provided:

**HMO / PPO / Other Insurance Coverage**

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license. **All co-payments are due prior to seeing the physician.** If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. **You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.**

**Medicare**

Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. **You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.**

**Laboratory**

Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

**Self-Pay Patients (Will Pay)**

For patients with no insurance, the guarantor is responsible for the bill at the time of service.

**Cosmetic Patients**

Deposits are required prior to the date of the procedure. The balance of the payment is required prior to the procedure being performed.

**Payments**

**Payments can be made by cash, check, VISA, Mastercard, Discover and American Express. We utilize a guaranteed check service which automatically deducts the amount of your check from your account immediately.** This is similar to how your credit or debit card works by showing us if funds are available in your account.

**Returned Checks and Collections**

A charge of \$20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services.

**X** \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Last Name, First Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SS #

**Benefits Assignment**

I hereby authorize the assignment of benefits (payments) directly to Long Island Skin Cancer and Dermatologic Surgery, P.C. for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

**X** Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**Records Release**

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

**X** Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_