DERMATOLOGY ASSOCIATES OF SOUTHERN NEW HAMPSHIRE

NAME_____

FIRST MI LAST

ADDRESS_____

STREET CITY STATE ZIP

PERSONAL INFORMATION

Date of Birth	Home Phone	Cell Phone
Social Security #	Employer	Work Phone
Emergency Contact	Relationship	Phone Number
Emergency Contact Name	First	Last

PRIMARY INSURANCE PLAN

Plan Name	Identification #	Group #
Subscriber's Name	Subscriber's Date of Birth	Relationship
Subscriber's Employer	City	State

SECONDARY INSURANCE PLAN

Plan Name	Identification #	Group #
Subscriber's Name	Subscriber's Date of Birth	Relationship
Subscriber's Employer	City	State

DO WE HAVE PERMISSION TO:

Please place check in box	**Yes**	**No**
Provide you treatment?		
Leave a message on your home voicemail or cell phone?		
Speak to anyone in your home to confirm appointments? - Name and relationship to you:		
Fax/mail medical information to your Primary Care Physician or referring physician? -Primary Care Physician name: -Referring Physician name:		
Discuss your medical condition with any specified family member? If yes, whom? - Name and relationship to you:		
Do you reside in assisted living or long term care? - If yes, where Phone #		
Do you have a durable Power of Attorney? -If yes, whom (name) -Relationship Phone #		

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SIGNATURE (will expire one year from date) DATE

Dr. Frank is NOT a participating provider for MEDICAID. If you have MEDICAID as your supplemental policy to Medicare you will be responsible for any balance remaining after Medicare has paid your claim.

SIGNATURE_____ DATE_____

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This office is required to keep your signature on file authorizing us to file claims to your commercial insurance for you and to release information to the payer if they require it for proper consideration of a claim. Please read and sign the following statement:

I understand that it is my responsibility to keep Dermatology Associates informed of any changes in my insurance status. I understand that an insurance claim will be submitted to my insurance carrier, however, this is no guarantee of payment. I realize I am responsible for any co-pays, co-insurance amounts and/or non-covered charges. I hereby authorize the release of requested information to process insurance claims to my insurance carrier only.

If you have an HMO or Managed Care Insurance plan, you are responsible for ensuring authorization for visits to our office. Without a valid referral, payment for services is your responsibility.

SIGNATURE_____ DATE_____

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This office is required to keep you signature on file authorizing us to file claims to Medicare for you and to release information to the payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for any Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either; to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE_____ DATE_____

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Signature as it appears on Medicare card

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses", we are required to keep a separate signature on file. (This pertains to many common secondary insurances including, <u>but not limited to</u>: AARP, BCBS Medicomp, Banker's Life, United Healthcare, Tricare and Aetna)

I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE_____ DATE_____

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1/9/13