DERMATOLOGY ASSOCIATES OF SOUTHERN NEW HAMPSHIRE

NAME: _____
FIRST MI LAST

ADDRESS: _____
STREET CITY STATE ZIP

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE PLAN NAME: _____

Identification # _____ Group # _____ Copay $ _____

Subscribers Name: _____ DOB: _____

Subscribers Employer: _____ Relationship: _____

SECONDARY INSURANCE PLAN NAME: _____

Identification # _____ Group # _____ Copay $ _____

Subscribers Name: _____ DOB: _____

Subscribers Employer: _____ Relationship: _____

DO WE HAVE PERMISSION TO:

Provide you treatment? ..... _____Y_____N

Leave a message on your home answering machine or cell phone? ..... _____Y_____N

Speak to anyone in your home to confirm appointments? ..... _____Y_____N

If yes, whom (NAME) _____

Fax/mail medical information to your Primary Care Physician (PCP) or referring physician?

If yes, name of PCP? _____

If yes, name of referring physician(s) _____

Discuss your medical condition with any specified family member? ..... _____Y_____N

If yes, whom (NAME) _____ **Relationship:** _____

Do you reside in assisted living or long term care? ..... _____Y_____N

If yes, where: _____ **Phone:** _____

Do you have a Durable Power of Attorney (DPOA)? ..... _____Y_____N

If yes, whom (NAME) _____ **Relationship:** _____ **Phone:** _____

_____ _____
SIGNATURE (Signature will expire 1 year from date) DATE

(Over)

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_____

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_____

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_____
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_____