***The Sections below MUST be completed for all patients:***

**New Patient \_\_\_\_\_\_\_\_\_\_ Existing Patient \_\_\_\_\_\_\_\_\_\_ Name Change \_\_\_\_\_\_\_\_\_\_**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

**Date of Birth:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ **Gender:** Male \_\_\_\_\_Female \_\_\_\_\_ **SSN:** \_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

**Home Phone** :(\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone** :(\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone :(\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Decline to provide email: \_\_\_\_\_\_\_\_\_  
Employment: Full time: \_\_\_\_\_ Part time \_\_\_\_\_ Unemployed\_\_\_ Retired \_\_\_\_  
Student: Full time\_\_\_\_ Part time \_\_\_\_\_ Not a student\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single \_\_\_\_ Married \_\_\_\_Domestic Partner \_\_\_\_ Divorced \_\_\_\_Widowed \_\_\_\_ Separated \_\_\_\_

**DO WE HAVE PERMISSION TO:**  ***Please Initial Yes or NO***

* **LEAVE A MESSAGE ON YOUR CELL PHONE?** YES\_\_\_\_\_ NO\_\_\_\_\_
* **LEAVE A MESSAGE AT HOME?** YES\_\_\_\_\_ NO\_\_\_\_\_
* **LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?** YES\_\_\_\_\_ NO\_\_\_\_\_
* **SEND AN EMAIL for visit confirmation?** YES\_\_\_\_\_ NO\_\_\_\_\_
* **DISCUSS YOUR MEDICAL CONDITION WITH ANOTHER PERSON?** YES\_\_\_\_\_ (***List Name*** *(****s****)* ***below***) NO\_\_\_\_\_

*If YES, With* ***WHOM can we speak?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Relation to patient:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party **if Different** from Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer/Retired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY PLEASE CONTACT:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number** (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

**Assignment of Benefits/Release:**

*I authorize the release of Medical information to my primary care or Referring Physician. I also request that payment of authorized insurance benefits including Medicare (****if applicable****) be made on my behalf to* ***Debbie Miller Dermatology*** *for the services furnished to me. I further understand my signature authorizes the release of medical information necessary to pay my claim. If other Health insurance is indicated on the registration from, or elsewhere, on other approved claim forms or electronically submitted claims, my signature below authorizes the release of that medical information to the insurer or agency shown. In MEDICARE ASSIGNED Claims, Debbie Miller Dermatology agrees to accept the charge determination of the Medicare Carrier as the full charge and I understand that I will be billed only for the deductible, co-insurance and all other* ***NON-COVERED*** *services based on the determination of the Medicare Carrier.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient** or **Responsible Party Relationship Date**

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***How did you hear about us?***

Internet\_\_\_\_ Doctor Referral\_\_\_\_ Radio\_\_\_\_ Newspaper\_\_\_\_ Friend\_\_\_\_ Phone Book\_\_\_\_ Other\_\_­­\_­­\_\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday for Primary Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday for Primary Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ My Insurance coverage is between me and my insurance carriers. I realize that **if I have not met**

**Initial** **my deductible, charges incurred today may be applied to my deductible, and I will be responsible for those charges**. I further understand it is **my responsibility to know what my**

**individual insurance benefits are.**

\_\_\_\_\_\_\_\_ I understand that if I do have insurance, and I **HAVE NOT presented the insurance card**, I will be

**Initial** **considered a PRIVATE PAY** patient and I will **be responsible for any charges**. Payment of those

charges are due at the time of service.

***Federal agencies require us to collect the following information regarding race and culture:***

**Race:** American Indian \_\_\_Asian \_\_\_Black/African American \_\_\_Native Hawaiian/Pacific Islander\_\_\_

White/Caucasian \_\_\_ Hispanic \_\_\_Unknown/other \_\_\_ **PATIENT REFUSED**\_\_\_\_

**Culture:** Latino/Hispanic \_\_\_ Not Latino/Hispanic \_\_\_ Unknown/Other \_\_\_ **PATIENT REFUSED** \_\_\_\_

**DEBBIE MILLER DERMATOLOGY FINANCIAL INFORMATION**

Debbie Miller Dermatology is contracted with several insurance groups and will be happy to bill your Insurance. **You may need to contact your insurance carrier to find out if we are contracted with your individual plan**. If Debbie Miller Dermatology has a contract with your insurance carrier, we are required by that contact to bill for any covered non-cosmetic services. Please be aware your insurance coverage is a contract between you and your insurance carrier, so if you **have any questions regarding your specific insurance coverage you will need to contact your carrier**. The customer service telephone number can be found on the back of your insurance card. **Your co-pay and any deductible not met are expected at the time of service**. **Any prices quoted to you are ESTIMATES**. The completed billing may differ from your estimate as we review all documentation for completion before we submit a final bill to your insurance carrier. Any balance due will be billed to you at that time and **payment is expected within 30 days** unless other arrangements are made with the billing department. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please Initial**

***Any treatment that you have done is considered a surgical procedure*** *and your insurance carrier may process your claim according to your major medical benefit. (****If you have questions regarding your major medical benefits please contact your insurance carrier****). This means that charges may be applied to your deductible, your carrier may pay only a percentage of the total charges or you may be billed for surgical co-insurance. We have no way of knowing your specific insurance coverage, so we cannot provide individual reimbursement information.* ***You will need to contact your carrier for your specific coverage information****.*

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**If we are not billing insurance, payment is due at the time of service**. **The cost of any service is not complete until the finished documentation of that visit is reviewed for accuracy and completion and you may be sent a statement after the visit with additional charges.**

Dr. Miller and Physician Assistant will determine if your procedures are medically necessary or considered cosmetic. ***Cosmetic procedures are to be paid in FULL at the time of service*** *and* ***WILL NOT be billed to your insurance carrier****.*

**Some methods of Treatment:**

The treatment of skin conditions depends on the type and location of the growth and the symptoms you are having. Dr. Miller and Physician Assistant will discuss the treatment options that are the best for you. Some forms of treatment are:

**Cryosurgery** – The destruction of skin tissue by freezing with liquid nitrogen*.*

**Curettage & Desiccation (C&D)** – Scraping of the skin with a sharp surgical instrument to remove tissue*.*

**Shaving or Tangential Excision** – *The horizontal removal of a lesion.*

**Surgical Excision** – *The site is injected with a local anesthetic followed by cutting into the skin with a surgical instrument, removing the growth and closing the wound.*

**\*\*Some treatments like Cryosurgery may require several visits to treat and each visit is a separate charge and will be billed separately. *This is especially true for treatment of warts*. \*\***

Debbie Miller Dermatology reserves the right to charge a $50.00 NSF (non-sufficient funds) fee on any check returned for non-payment or declined credit card and you will be required to pay a deposit of $150 before any further appointments can be made.

Debbie Miller Dermatology reserves the right to charge $25.00 for any office visit not cancelled within 24 hours.

When Dr. Miller or Physician Assistant biopsies or removes a lesion, there will be a billing charge for reading and processing the pathology. **This charge will be in addition to any procedure and office visit charges**. **OCCASIONALLY, your pathology slide may be sent out to ANOTHER pathology laboratory for a SECOND OPINION**; in this case, you will receive a bill from that outside pathology office as well as our office. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please Initial**

***I certify that I have read and fully understand the Debbie Miller Dermatology, PC, financial policy and I have had my questions answered.***

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**

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