



Today's Date: _____

WELCOME TO OUR OFFICE

PATIENT INFORMATION:

Patient's Full Name _____ Marital Status S___ M___ W___ D___
 Driver's License # _____ Birth Date _____ Age _____ Sex M___ F___
 Mailing Address _____
 City _____ State _____ Zip _____
 Patient's Phone Info: Home (____) _____ Cell (____) _____ Business (____) _____
 Occupation _____ Employer _____

EMERGENCY CONTACT NAME: _____ Phone Number (____) _____
PHARMACY NAME: _____ Phone Number (____) _____
REFERRING DOCTOR: _____
PRIMARY CARE DOCTOR: _____

MEDICAL INSURANCE: HMO PPO **CO-PAY \$** _____
 Primary Company _____ Secondary Company _____
 Insured (Subscriber) _____ Insured (Subscriber) _____
 Insured's Relationship to Patient _____ Insured's Relationship to Patient _____
 Insured's Date of Birth _____ Insured's Date of Birth _____
 Member ID # _____ Member ID # _____
 Group or Policy # _____ Group or Policy # _____
 Effective Date (date coverage began) _____ Effective Date (date coverage began) _____

PERMISSION TO DISCUSS MEDICAL INFORMATION WITH FAMILY MEMBERS:
 Do you give our office permission to discuss medical information with family members? Yes No
 If yes : Name _____ Relationship _____
 Name _____ Relationship _____
 Patient Signature: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?
 Physician Yellow Pages Other _____
 Insurance Directory Family or Friend (name) _____

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to the undersigned.

Carolina Skin Surgery Center, P.A. Charlotte, North Carolina

Please remember that medical insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-pay, co-insurance or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company, including obtaining authorizations and referrals. You must inform our office prior to receiving service if your insurance coverage is through an HMO. Information regarding any change in your insurance coverage must be provided prior to receiving service.

As a courtesy, our office will file your insurance after receiving a service in our office. You will not receive a statement from Carolina Skin Surgery Center until your insurance has either paid their portion of the charges or denied payment of the claim. Denials are often due to your deductible not having been met, a non-covered service defined by your plan, or non-eligibility in the plan at the time the service was rendered.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record to the patient's insurance company.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment is to be considered as valid as an original.

Signature of Patient _____ Date _____
Signature of Responsible Party _____ Date _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to Carolina Skin Surgery Center, P.A., Dr. Carruth, or to his associates for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Signature of Beneficiary _____ Date _____

LIFETIME CONSENT

I request that payment of authorized Medigap benefits be made on my behalf to Carolina Skin Surgery Center, P.A., Dr. Carruth, or to his associates for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary _____ Date _____

Medigap Insurer _____ Patient's Medigap # _____

MEDICAL RECORDS COPY FEE

A \$10.00 minimum fee may apply for costs incurred in the preparation and photocopying of medical records. All requests for copies of medical records must be made in writing.

Specializing in the Diagnosis and Treatment of Skin Cancer