Integrated Dermatology
MedSpa of Groton

(This information is confidential)

Patient name: First_____Middle_____Last_____

Street Address_____Town_____Zip_____

Preferred phone_____(is this cell, home or work?)

Secondary phone_____(is this cell, home or work?)

Email _____ SS#_____

Birth date_____Marital status_____Name of spouse (or parent)_____

Employer_____Address (city)_____

(For minor) parent or guardian name:_____Relationship_____

Address_____Town_____

	Yes	No
May we leave a message on your answering machine?		
May we speak with or leave a message with your spouse / parents? (if so, please list names)		
May we contact you by cell phone?		

Primary insurance company name_____

Insured name_____Relationship to patient_____

Insured birth date (if different from above)___/___/_____Insured employer_____

ID#_____Group number_____Social Security #_____

Secondary insurance company name_____

Insured name_____Relationship to patient_____

Insured birth date (if different from above)___/___/_____Insured employer_____

ID#_____Group number_____Social Security #_____

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of insurance benefits. I authorize payment for medical services rendered and authorize release of any medical information necessary to process this claim.

Signed_____ Date___/___/____

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Date: _____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We file with secondary/supplemental carriers. Medicare does not cover cosmetic procedures.

HMO, PPO or other managed care patients: You will responsible for paying your annual deductible, copayment and charges for any non-covered or cosmetic procedures.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the bill at the time of service. The office may agree to bill insurance first in the case of expensive surgical procedures. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient, legal guardian, or responsible party signature _____ **Date:** _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor 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 the Centers for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related 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 as it appears on Medicare Card _____ **Date:** _____

If you have a supplemental policy and it is MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

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

Signature as it appears on MEDIGAP card _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Integrated Dermatology

481 Gold Star Highway, Suite 201
Groton, CT 06320
(860)445-8020

Patient Name_____

I hereby acknowledge that I have been offered a summary or full copy (my Preference) of the Integrated Dermatology Notice of Privacy Practices. I understand that I may request a copy of any amended Notice of Privacy Practices at any time.

Signed_____ **Date**_____

Printed name_____ **Phone**_____

If not signed by the patient, please indicate your relationship to the patient: _____

_____

_____

For office use only:

Signed form received from_____

Refused to sign:

Reason for refusal:_____

Efforts to obtain: _____