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FACE SHEET

Name _____ Date of Birth _____ Age _____ Sex _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Employer Phone # _____

Social Security # _____ Emergency Contact _____

Primary Physician _____ Referring Physician _____

*Primary Insurance _____ ID Number _____

Cardholder's Name _____ Cardholders SSN # _____

Relationship to Patient _____ Cardholder's Date of Birth _____

Cardholder's Employer _____

*Secondary Insurance _____ ID Number _____

Cardholder's Name _____ Cardholder's SSN # _____

Relationship to Patient _____ Cardholder's Date of Birth _____

Cardholder's Employer _____

I hereby authorize my insurance benefits including Medicare to paid directly to Gulf Coast Dermatology. This assignment will remain in effect until revoked by me in writing I understand that I am financially responsible for all charges whether or not paid by said insurance. I herby Authorize said assigned to release all information necessary to secure that payment. In the event that this account is assigned to collections, I agree to pay all cost of collection including reasonable attorney fees. It is the policy of Gulf Coast Dermatology to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. If you believe you have been denied a benefit of some service because of your race, color, national origin, religion, sex, age or disability, you may file a complaint of discrimination with our office, either verbally or in writing.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ Date ____/____/_____

PAYMENT POLICY:

HMO, PPO, or other managed care patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered and cosmetic services at the time of service.

COMMERCIAL PATIENTS WHO ARE NOT IN-NETWORK: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the total bill at the time of service.

COMMERCIAL PATIENTS WHO ARE IN-NETWORK: Patients who are covered by private, commercial plans in which our physicians are providers will be required to pay the balance of the bill before or on the date of your next visit if we have not been paid from your insurance company within 60 days we will provide you with the information necessary to contact your insurance company upon request.

PLEASE BE ADVISED, THERE MAY BE ADDITIONAL COSTS FROM OUTSIDE LABORATORIES. OUR BIOPSIES ARE SENT TO OUR PREFERRED PATHOLOGIST/ LABORATORY IN TALLAHASSEE, FL, KETCHUM, WOOD & BURGETT (KWB) AND DERM PATH. GROUP RESOURCES WILL BE SENT TO BAY MEDICAL. IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY TO VERIFY THAT THESE LABS ARE IN THE NETWORK.

Patient or Responsible Party Signature _____ Date ____/____/_____