Jon Ward, M.D.
2420 Jenks Avenue, Suite C-1
Panama City, Florida 32405

Name____ Date of Birth___________ Age____ Sex _________

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.

TO BE ADVISED THERE MAY BE ADDITIONAL COSTS FROM OUTSIDE LABORITORIES. IT IS THE PATIENTS RESPONSIBILY TO MAKE SURE YOUR INSURANCE COMPANY IS IN-NETWORK WITH THEM.

Patient or Responsible Party Signature___________________________________Date ____/____/____