Skin & Laser Surgery Center, P.C.

Dermatology, Laser, Cosmetic & Mohs Skin Cancer Surgery

1359 Beverly Rd 2nd Floor Mclean, VA 22101•2200 Opitz Blvd, Suite 100, Woodbridge, VA 22191

PATIENT INFORMATION

Todays Date: (month) _____/(day)_____/(year)_____ Preferred Language: ☐English ☐Spanish ☐Other_____

Name: _____
(Last) First) (MI)

Do you have a preferred name or nick name?: _____

Sex: ☐Male ☐Female **Date of Birth**: _____/_____/_____ Age: _____ **Social Security #**: _____-_____-_____

Address: _____
(Street Address) (Town/City) (State) (Zip)

Home Telephone No: (_____)_____Cell Phone No: (_____)_____

What is the best way for us to reach you? ☐Home ☐Cell ☐Other Phone (_____)_____

May we leave a message about your test results? **YES/NO** with ☐Spouse, ☐Voicemail, ☐Other_____

Marital Status: ☐Single ☐Other_____ ☐Married *__Email__: _____@_____

*Can we send you any information via your email? **YES/NO**

Race: _____ **Ethnicity**: _____

How would you like to receive appointment reminders? □E-mail □Call

Name of parents or guardian (**if patient is child or under 18 years old**)

Father: _____ Address:_____
Mother:_____ Address:_____
Guarantor:_____ Address:_____

Emergency Contact Name: _____Phone: (_____)_____

Is patient employed? **YES/NO** (Please Circle) If employed, please fill out the following:

Name of Employer: _____ Phone: (_____)_____

ADDITIONAL INFORMATION

Name of PRIMARY CARE PHYSICIAN: _____

Address: _____
(Street Address) (Town/City) (Zip)

Phone: (_____)_____ Fax: (_____)_____

Please list any other physicians who you see: _____

_____

Name of PHARMACY: _____ Phone: (_____)_____

Address: _____
(Street Address) (Town/City) (Zip)

How did you hear about us? Please Circle ALL that applies**:**

a. Insurance Company Website or Directory
b. Friend/ Relative/Colleague_____
c. Doctor's Name: _____
d. Yellow Pages (Verizon / Yellow Book/ Local-Community Book)
e. Google Search/Internet/Website name: _____
g. Other _____

HIPAA PRIVACY AUTHORIZATION

I have the right to review the Notice of Privacy Practices prior to signing this consent.

☐**I authorize** Skin & Laser Surgery Center, PC to use and disclose my protected health information for its own purposes of treatment, payment, and health care operations. This authorization expires one year from date of signing. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity. **Initials**_____
You have the right to receive a copy of this authorization. If you would like to list an individual to recieve your medical records, please list them below.

First name _____ Last name_____

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

PLEASE TURN OVER.

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PRIMARY Insurance Information

IF YOU HAVE MEDICARE DO YOU HAVE A MEDICARE REPLACEMENT PROGRAM ☐YES ☐NO

Name of Policy Holder_____

Date of Birth of Policy Holder: _____/_____/_____ **Social Security # of Policy Holder:** _____-_____-_____

Name of Primary Insurance: _____ **ID NO:** _____

Primary Insurance Co. Phone #: (_____**)**_____ **Group #:** _____

Policy Holder's Address: _____
(Street/P.O. Box) (Town/City) (State) (Zip Code)

Employer Insurance Plan? ☐Yes ☐No

Relationship of Patient and Policyholder: ☐Self ☐ Husband ☐Wife ☐Child ☐Parent

SECONDARY Insurance Information

Name of Policy Holder_____

Date of Birth of Policy Holder: _____/_____/_____ **Social Security # of Policy Holder:** _____-_____-_____

Name of Secondary Insurance: _____ **ID NO:** _____

Secondary Insurance Co. Phone #: (_____**)**_____ **Group #:** _____

Policy Holder's Address: _____
(Street/P.O. Box) (Town/City) (State) (Zip Code)

Employer Insurance Plan? ☐Yes ☐No

Relationship of Patient and Policyholder: ☐Self ☐ Husband ☐Wife ☐Child ☐Parent

ASSIGNMENT & RELEASE

I hereby authorize Skin & Laser Surgery Center, PC to apply for benefits on my behalf for covered services rendered. I, further, authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). Either my insurance carrier or I may revoke this authorization at any time in writing. I certify that information I have reported with regard to my insurance coverage is correct. I authorize Dr. Bajoghli, Associates and staff to treat me. I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Skin & Laser Surgery Center, PC for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

***In the event my health plan determines a service to be non-covered, I will be responsible for the complete charge. Skin & Laser Surgery Center, PC will bill me directly and payment is due upon receipt of the statement. Skin & Laser Surgery Center, PC will also bill your health plan for all services we provide in the hospital. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment**.

I understand and agree that *I am financially responsible for charges not covered by my insurance* company.

APPOINTMENT POLICY

There will be a $85.00 charge for a NO SHOW office visit or an $150.00 charge for NO SHOW SURGERY appointment. We strictly enforce this policy, so please take time to carefully select your appointment time. A broken appointment is a cancellation without a 24-hour notice, lateness that results in the inability to properly complete the treatment planned, or not being present for the scheduled appointment.

PAYMENT POLICY

Self pay accounts, co-pay, deductibles and/or co-insurances are due at the time of service; there is no exception to this policy. If it becomes necessary Skin & Laser Surgery Center, P.C will turn your account over to a collection agency/attorney.

If your check bounces (due to insufficient funds or any other reason) you will be charged $50.00 ASF Fee.

INSURANCE COVERAGE

It is not Skin & Laser Surgery Center's responsibility to confirm whether the patient has in-network or out of network benefits. Ultimately, it is the patient's responsibility to confirm what their coverage benefits are with their insurance company.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE