

Medicare Patient Information

Name _____ Birth date _____ Age _____

SS# _____ Marital Status _____ If Yes, Spouse's Name _____

Home Address _____
Street _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Emergency Contact _____ Phone Number _____

____ YES, I would like an appointment reminder via email! Email address _____

Please read each of the following and answer as they apply to you.

YES

NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company which has more than 20 employees & have coverage through the insurance at that job? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by a HMO/PPO which makes Medicare secondary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work and have coverage through the insurance at your job? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you eligible for any benefits under the Federal Black Lung Program? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office for an illness, accident or injury that is the result of an automobile accident? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office due to Medicare disability coverage? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by the Federal End Stage Renal Disease Program? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently receiving Workers' Compensation? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the illness or injury you are coming to this office for the result of work-related causes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have medical assistance through Welfare or state-aid? |

If you answered YES to any of the above questions please give this information to the receptionist.

Medicare Health Insurance Claim Number as it appears on your Medicare Card:

(This is usually your social security number. Be sure to include the letter with the 9 digit number. We need both the number and the letter)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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.

-Continued on Back-

Date _____ Signature _____

Supplemental Information:

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare.

Name of Insurance Company _____

Policy Number _____ Group Number _____

Please sign so we may have your Supplemental Authorization on File:

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

Date _____ Signature _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or going to www.LovelySkin.com/privacy.

Photographs may be taken to display your condition to fellow dermatologists for research or diagnostic reasons. No personal data will accompany any photograph taken.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

I authorize Skin Specialists, P.C. to send me promotional materials from Advanced Skin Research Center and LovelySkin, Inc.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Skin Specialists has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Skin Specialists reserves the right to change the Notice of Privacy Practices
- I have the right to restrict the uses of my information but Skin Specialists does not have to agree to those restrictions
- I may revoke this Consent in writing at any time and all future disclosures will then cease
- Skin Specialists may condition receipt of treatment upon the execution of this Consent.
- Cash, checks and all major credit cards are acceptable forms of payment, however if a check is returned for any reason you will be charged a returned check fee of \$70.00 minimum.

This Consent was signed by: _____
Printed Name – Patient or Representative

	_____	/____/____
	Signature	Date
Witness	_____	/____/____
	Signature – employee of Skin Specialists, P.C	Date