PATIENT INFORMATION

Patient Name: ____ ______-_____-_____
Last First MI Social Security Number

Address: ____ ______-_____-_____
Street Apt/P.O. City State Zip Date of Birth

E-mail Address: ____ Male ☐ Female ☐

Bill to (if different from above):____

Home Phone: ____________ Cell Phone: _______________ Work Phone: ______________

Race: American Indian ☐ Asian ☐ Native Hawaiian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other ☐

Primary Language: __________________ Marital Status: _______ Employer Name: _________________

RESPONSIBLE PARTY

Name: ____ ______-_____-_____
Last First MI Social Security Number

Address: ____
Street Apt/P.O. City State Zip

Home Phone: ____________ Cell Phone: _______________ Work Phone: ____________________________

EMERGENCY CONTACT

Emergency Contact Name: ____ ___________________________
Last First MI Relationship

Address: ____
Street Apt/P.O. City State Zip

Home Phone: ____________ Cell Phone: _______________ Work Phone: ____________________________

PHARMACY

Pharmacy Name: ____________________________ Pharmacy Phone: _________________________________

Address: ____
Street Apt/P.O. City State Zip

Primary Care Physician___________________________ Primary Care Physician Phone: ____________________
Referring Physician______________________________ Referring Physician Phone: _______________________

INSURANCE

Primary Insurance Name_________________________ **Secondary** Insurance Name______________________
Insurance Address______________________________ Insurance Address_____________________________
Insured's Name________________________________ Insured's Name_______________________________
Insured's Date of Birth___________________________ Insured's Date of Birth_________________________
Insured's ID#__________________________________ Insured's ID#________________________________
Group #______________________________________ Group #_____________________________________
Employer Name________________________________ Employer Name_______________________________
Relationship of Patient to Insured____

Precertification & Financial Responsibility: I understand that the insurer will review the planned course of treatment and decide regarding the medical necessity of the services, and then issue certification of my plan benefits. Galloway Dermatologic Surgery, LLC will make every effort to inform you when precertification is required, however, due to multiple payer rules among plans with whom we participate, it is impossible for us to always know which services are payable according to your insurance company's policy. We will work with you to insure precertification for services we are aware require it. If precertification is late, refused, or denied at any time, then payment for the services is the responsibility of the patient or financially responsible person(s).
I have read and understand the above consent __________(Initials)

Assignment of benefits: I assign and transfer to Galloway Dermatologic Surgery, LLC all medical provider benefits related to the services rendered. I authorize and direct the insurance carrier to apt all benefits to Galloway Dermatologic Surgery, LLC. I understand that I am responsible for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between Galloway Dermatologic Surgery, LLC and the insurer.
I have read and understand the above consent __________(Initials)

Consent to release Claims Information: I hereby authorize Galloway Dermatologic Surgery, LLC, its employees and agents to release all information concerning my (or the patients) medical care and treatment for purpose of treatment, health care operations and for claims payment as provided for in the Health Insurance Portability and Accountability Act (HIPPA). I understand that I may request restrictions to the uses of my information with written notice. I also understand that restrictions to the use of my information for the purposes outlines in this paragraph are subject to agreement by Galloway Dermatologic Surgery, LLC.
I have read and understand the above consent___________(Initials)

I HAVE READ THE FRONT AND BACK OF THIS FORM AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, AND ASSIGNMENTS PRINTED AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

Patient's Printed Name____

Signature of Patient____ Date________________

I am legally authorized to provide consent on behalf of the patient listed above.
My relationship to the patient is described as follows:

Signature of Authorized Representative____

Relationship to Patient____

Witness____