CINCINNATI DERMATOLOGY CENTER

7730 MONTGOMERY RD, SUITE 200
CINCINNATI, OHIO 45236

Personal:

Last Name ______ First Name ______ Middle Initial ______

Street Address ______ City/ State ______ Zip Code ______

Social Security Number ______ Date of Birth ______ Age ______ Sex ______ Marital Status ______

Home Phone # ______ Work Phone # ______ Cell Phone # ______ Email ______

Employment:

Name of Employer ______ Phone Number ______ Occupation ______

Street Address ______ City/ State ______ Zip Code ______

Emergency Contact:

Name ______ Home Phone ______ Cell Phone ______ Relationship to You ______

Family Physician:

Name ______ Phone Number ______

Street Address ______ City/ State ______ Zip Code ______

Who referred you to this office: ______

Insurance: We will need to make a copy of your card(s) today.

Name of Primary Insurance ______ Name of Secondary Insurance ______ Name of Tertiary Insurance ______

Relationship to insured ______ Relationship to insured ______ Relationship to insured ______

Signature of Patient (or patient representative) ______ Date ______

Authorization to Release Medical Information and Claim Payment Authorization
I hereby authorize the Cincinnati Dermatology Center to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I hereby assign all medical and/or surgical benefits to which I am entitled including private insurance and other health benefit plans to the Cincinnati Dermatology Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Date_________________ **Signature**____

I hereby authorize and direct my insurer to issue payment checks for benefit due me for the services rendered by the above named physician to be made directly to him. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

Date_________________ **Signature**____

Medicare Only:

Statement to Permit Payment of Medicare Benefits to Provider, Physician, and Patient
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.
I request that payment under the medical insurance program be made either to me or to the above named physician.
Date_________________ **Signature**____

OFFICE POLICIES

"NO CALL"/ "NO SHOW" POLICY:

Due to many patients not showing up for their set appointments, it has become necessary for this office to implement a $35.00 fee for all appointments that are not cancelled with 24 hours advanced notice. This cancellation may be left on our answering service. Simply leave the date and time along with your message. This fee is not billable to your health care plan.
NOTE: Emergencies, bad weather and other situations will be considered on a case by case basis.
Questions may be directed to our billing department.
This courtesy will allow us to better serve our patients. We thank you for your cooperation.

LEDGE AND SUPERBILL FEES:

If you require a copy of your superbill for HSA, HRA, OR FSA accounts please request this at your appointment.
The fee for these after your appointment are $10 for a ledger and $5 per superbill. This is not billable to your healthcare plan.

I am aware of this office's policy regarding Superbills and Ledgers, and no shows

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DATE **SIGNATURE OF PATIENT OR REPRESENTATIVE**