

PATIENT REGISTRATION FORM

Name _____ Today's date _____
Last First M I

Guardian _____ Date of Birth ___/___/___
Last First M I

Mailing Address _____ Age _____
Number, Street, Apartment Number

City _____ State _____ Zip _____

Home Phone (____) _____ Work phone (____) _____ Cell Phone (____) _____

Patient Date of Birth ___/___/___ SS # _____ - _____ - _____ Marital Status _____ Male/Female _____

Occupation _____ Retired _____ Full Time Student _____ Part Time Student _____

Employer _____ Spouse's Name: _____

Person to notify in case of emergency _____ Phone _____

Relationship _____ (Please list a person not living in your home)

Referring Doctor _____ Primary Care Physician _____

Preferred Pharmacy _____ Location/Address _____

May we leave a **brief** message on your home or cell phone? Y N
May we leave an **extended** message on your home or cell phone? Y N
May we leave a message for you at work to call us? Y N
May we discuss your medical condition with another person? Y N

If yes, whom _____ Relationship _____

How did you hear about our practice? _____

Primary Insurance Company _____ Policy/ID # _____ Group # _____

Policy Holder Name _____ Relationship to patient _____ DOB _____

Secondary Insurance Company _____ Policy/ID # _____ Group # _____

Policy Holder Name _____ Relationship to patient _____ DOB _____

ASSIGNMENT OF BENEFITS: I hereby assign all applicable benefits and direct that payment to be made directly to Idaho Skin Surgery Center (ISSC), for all services provided to/for me during my visits. RELEASE OF INFORMATION: I authorize ISSC to furnish medical and other information necessary to process claims on my behalf. This information may be released to my personal physician and upon request to any of the health care provider(s) who may need the information for continuity of care. This release of information will remain in effect until revoked by me in writing. FINANCIAL RESPONSIBILITY: I understand and agree that I am responsible for payment of all charges, including those not paid by my insurance in a reasonable time. TREATMENT AUTHORIZATION: The patient willfully requests treatment and consents to services provided by, or at the direction, of Dr. Scott. I authorize a copy of this document to be used in place of the original. NOTICE OF PRIVACY PRACTICES: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by ISSC.

Patient or Guardian: _____ **Date:** _____

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST



Here at Idaho Skin Surgery Center we understand that you may need to cancel or reschedule your appointment. Patients who fail to show for their appointments and who do not notify the practice in advance are costly to the practice and may prevent a sick individual who needs to be seen from getting a preferred appointment time. **If you are unable to keep your appointment, please notify our office with a minimum of 24 hours notice.** This will help us fill our cancelled spaces as well as shorten the waiting period for our patients.

The definition of a “Cancelled Appointment” is any cancellation that is less than 24 hours. A “No-Show Appointment” is defined as an appointment where there was no attendance and no notice was given. Due to our busy schedule, it has become necessary to implement a Cancellation and No-Show policy.

Please read and review the following policy:

- 1.) Please cancel your appointment with a minimum of 24 hours notice.**
- 2.) No-Show appointments will result in a \$25.00 fee. Your insurance will not be billed for this fee. It will be your sole responsibility to make sure it is paid before your next visit.**

I have read and understood the cancellation and no-show policy for Idaho Skin Surgery Center. I also understand it is my responsibility to plan appointments and notify Idaho Skin Surgery Center if I will have difficulty meeting my scheduled appointments.

Patient or Guardian's Name

Date

Financial Policies

We are pleased to serve you as your Health Care Provider and are committed to providing you with the best possible care. Please understand that payment for our services is considered a part of your treatment and your obligation to us. The following is a statement of our Financial Policies which we require you to read and sign prior to treatment. **All patients must complete our Registration forms prior to seeing the Doctor.** We will request to scan your insurance card(s) and drivers license for our files.

All Payments Due At the Time of Service. The office maintains a pay at the time of service policy.

For Patients with Insurance

In order for us to correctly bill your insurance, we must have the correct information. All copayments, coinsurance and deductibles are due at the time of service. Your insurance policy is a contract between you and your insurance company; we are **not** party to that contract. In the event that we do not participate with your insurance, you will be responsible for any balance your plan indicates as due when we verify your insurance. *If you have a new insurance or change insurance plans, you must provide us with clear and accurate insurance information as soon as possible. You will be responsible for payment of any visits that may have occurred if we do not receive the information within 30 days.*

Self-pay patients are expected to pay in full at the time of the visit. There is a \$250.00 (for office visits only) deposit due on the date of service **before** you see the doctor. If the charges exceed the \$250.00, and you cannot pay in full, you will be required to sign a promissory note for the remaining balance which will outline the payment arrangements. **(All payment arrangements must be authorized by the office manager prior to any procedures or surgeries.)** If the charges do not exceed the \$250.00, we will refund any remaining dollar amount, unless there is a follow-up visit that it can/will be applied to. Refunds will be mailed no later than 30 days after the visit. If a self-pay patient is having a surgery, **we will require \$1500.00 the day of surgery.**

Statements

Should you have a balance with our office after we receive an explanation of benefits from your insurance carrier, we will send you a statement. If we have not received a payment within 30 days, there will be an additional statement with a Past Due Notice mailed to you. If we do not receive a payment within the next 30 days, you will be mailed one more statement with a Delinquent Notice and possible collection action. Though we will try to remind you at each visit, it is ultimately **your** responsibility. If there is a credit of \$5.00 or less it will be written off or applied to another date of service, should there be a balance. There will be an additional \$35.00 charge for checks denied by your bank and/or returned for any reason. **We reserve the right to terminate the physician patient relationship due to failure to make timely payments.**

Medicare

We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance should the patient have one.

Medicare Patients: Signature on File

For the convenience of our Medicare patients and to expedite billing of services to Medicare on their behalf, ISSC will request and maintain your signature on file.

Minor Patients

The adult accompanying a minor and the parents/legal guardian of the minor are responsible for full payment. If a minor is unaccompanied by an adult/legal guardian without prior payment arrangements, we will **not** be able to see the minor. If a child needs to be seen in our office with someone other than an adult/legal guardian, a Medical Consent for Treatment Form must be filled out **before** the minor will be seen for non-emergency treatment. These forms can be obtained from our office or website at: idahoskinsurgerycenter.com.

Divorced Parents/Legal Guardians

ISSC will not be involved with separation or divorce disputes. Unless there is a court document that states otherwise, **both parents** are responsible for the payment. Please have payment arrangements worked out **before** the appointment. The best way to avoid this issue is for both parents to come to each visit. Similarly, if a parent is not present for an appointment for their child and requests a phone call to discuss appointment-related information, our office will request that parent make an appointment with the provider to discuss the information.

Non-covered/Cosmetic Services

Any care not paid for by your existing insurance coverage will require payment in full at the time services are rendered.

Appointment reminders and Missed appointments

Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. If you **do not** wish to have reminder calls, please notify our office. At times it may be necessary to cancel or reschedule your appointment. We require a minimum of 24 hrs in advance if you will not be able to make your appointment. This will help us to fill the appointment time as well as shorten the waiting period for our patients. Missed or no-show appointments will be subject to a \$25.00 fee that will **not** be billed to your insurance. It will be your sole responsibility to make sure it is paid before your next visit. Patients who miss three or more appointments without notice may be dismissed.

FOR YOUR CONVENIENCE, WE DO ACCEPT CASH, CHECK, MASTERCARD, VISA, AMERICAN EXPRESS, AND DISCOVER.

Idaho Skin Surgery Center ◊ 222 N. 2nd St., Suite 315 ◊ Boise, ID 83702 ◊ (208) 433-1114

Copying Fees

There will be a \$10.00 charge plus \$.50 per page for copying and any postage due for medical records that you request. If we are referring you to another physician, there will be no charge.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read, understand, and agree to this Financial Policy.

Responsible Party Signature

Date