Benson Dermatology & Skin Cancer

(PLEASE PRINT CLEARLY)

Full Name_____ Home Phone (____) _____

Address_____ Work Phone (____) _____

City_____ State _____ Zip_____ Cell Phone (____) _____

Social Security #_____-_____-_____ Email _____@_____

Date of Birth_____ Preferred method of contact (circle one):

Marital Status: Single Married Divorced Widowed HOME WORK CELL

Gender: Male Female

EMERGENCY CONTACT

(Person to contact in case of an emergency)

Full Name_____ Relationship to Patient _____

Home Number (____) _____ Other Number (____) _____

PATIENT INFORMATION

Occupation/School: _____

Circle one: Race: White Black Asian Hispanic Other: _____

Ethnicity: Hispanic Not Hispanic

Primary Language: English Spanish Other: _____

Over the age of 65: Do you have an Advance Directives (Living Will)? YES NO

INSURANCE

Primary Insurance

Subscriber's Full Name _____

Address _____ City _____ State_____ Zip _____

Employer /School _____

Date of Birth _____ Phone Number (____) _____ Relationship to Patient _____ Gender: M/ F

Insurance Company _____ Group #_____ Policy #_____

Address _____ City _____ State_____ Zip _____

Secondary Insurance

Subscriber's Full Name _____

Address _____ City _____ State_____ Zip _____

Employer /School _____

Date of Birth _____ Phone Number (____) _____ Relationship to Patient _____ Gender: M/F

Insurance Company _____ Group #_____ Policy #_____

Address _____ City _____ State_____ Zip _____

RESPONSIBLE PARTY

(REQUIRED IF PATIENT IS UNDER THE AGE OF 18)

Full Name_____

Address_____ City_____ State _____ Zip_____

Employer/School _____ Date of Birth_____ Phone # (____) _____ Relationship to Patient_____

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Patient Name: _____

Height: _____ **Weight:** _____

Preferred Pharmacy: _____

Type of Visit: ____ New ____ Follow-up

Referred By: _____

Past/Present Medical History:

___Anemia	___Heart disease	___Pace maker/defibrillator
___Arthritis	___Hepatitis	___Pregnant
___Asthma	___High blood pressure	___Rash
___Autoimmune disorder	___High cholesterol	___Rheumatic fever
___Bladder infections	___HIV	___Scarlet fever
___Bleeding tendency	___Kidney disease	___Shingles
___Cancer (skin/other)	___Measles	___Stroke
___Chickenpox	___Melanoma	___Thyroid disease
___Dementia	___Migraine headaches	___Tuberculosis
___Diabetes	___Mitral valve prolapse	___Venereal disease
___Epilepsy/seizures	___Mumps	___Whooping cough

Other: _____

Surgeries: _____

_____

Present Medications: _____

_____

_____

Allergies: _____

Vaccines: Influenza Y/N (Date):_____ **Pneumococcal** Y/N (Date):_____

Social History: ____ Smoking ____ Alcohol ____Drug abuse

Family History: ____Skin cancer ____Melanoma ____Rash ____Diabetes

Other:

_____

_____

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FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment by Benson Dermatology of the person _____ and agree to pay all charges including copayments for such treatment upon check out of each visit.

I agree that this office will prepare and file any claims which I have in connection with treatment received, and I agree, as evidence by my signature, to assign payment of any applicable benefits payable by my insurance company to this office. I also authorize the release of all information necessary to secure payment of my claim and the downloading of any medical history by Benson Dermatology. A copy of this authorization will be considered as valid as an original.

I understand Benson Dermatology is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for any or all amounts which insurance does not pay, including deductibles, co-insurance, or charges not covered. I understand any unpaid balance after 90 days from the date of service may be turned over to our collection agency for further collection. I am responsible to pay all reasonable collection agency cost.

We value our patient relationships and want to protect patients' rights. We will terminate patients from our practice after consideration for reasons including not showing for too many appointments, not complying with medical care, being hostile to ANY staff member, or not paying your bills.

X SIGNATURE_____ **DATE** _____

Notice of Privacy Practices

I have read and understand the Notice of Privacy Practices.

X SIGNATURE_____ **DATE** _____

Release of Medical Records

I hereby authorize the following individuals to retrieve my medical history including laboratory findings. I am also aware of the medical record fees: $5.00 handling fee plus $0.75 per page and postage cost if records are to be mailed.

X SIGNATURE_____ **DATE** _____

Individuals and/or family members that I give permission to retrieve my medical history including laboratory findings:

Name	Date of Birth	Relationship to Patient

INTEGRATED DERMATOLOGY GROUP, LLC

180 North 5th Street
Ponchatoula, LA 70454

190 Greenbriar Blvd., Ste 103
Covington, LA 70433

309 West Walnut St., Ste A
Amite, LA 70422

29799 South Walker Rd
Walker, LA 70785

Financial Policy

Our practice firmly believes that a good provider/patient relationship is based upon mutual respect and good communication. We are committed to providing you with the best medical care available while being mindful of costs related to your treatment. The following is our financial policy:

Payment:

1. All copayments, co-insurance, and deductibles are due at the time of service, regardless of who brings in the patient for his/her appointment. Sitters, grandparents, divorced parents, etc., must be prepared to pay at the time services are rendered. Our offices accept MasterCard, Visa, Discover, and American Express.
2. Overpayments will be refunded to the responsible party of the patient after all charges have been processed and paid by your insurance company.

Insurance:

1. Our office participates in a variety of insurance companies. It is your responsibility to:
   - A) Bring your insurance card(s) to each visit and notify us of any changes.
   - B) Know your copayment, co-insurance, and deductible amounts and be prepared to pay this amount at the time services are rendered.
   - C) Know your insurance company benefits (office visit coverage, diagnostic testing, etc.).
   - D) If you are enrolled in a managed care insurance plan (HMO), it is your responsibly to obtain or ensure a referral is issued to our office from your primary care physician prior to the time of your appointment. If no referral is on file, you will be asked to reschedule your appointment.
2. We file to secondary insurances as a courtesy. If your secondary insurance has not paid the outstanding balance within 60 days of the date claim was filed, you will automatically become responsible for the balance of any unpaid charges.

Returned checks:

The charge for a returned check is $25.00 payable by cash or credit/debit card. This will be applied to your account in addition to the insufficient funds amount. You will then be placed on a "cash or credit/debit card only" basis following any returns. If payment for an insufficient check is not made within 10 business days, your check will be turned over to the district attorney office, and you will be responsible for all court cost that may be involved.

Unpaid balances:

I understand Benson Dermatology is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for any or all amounts which insurance does not pay, including deductibles, co-insurance, or charges not covered. I understand any unpaid balance after 90 days from the date of service may be turned over to our collection agency for further collection. I am responsible to pay all reasonable collection agency cost.

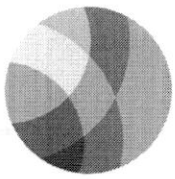
Patient Authorization

I consent to treatment, including biopsies, necessary for the care of the below named patient. I understand that I will receive a separate bill from the laboratory for each skin specimen (by law our providers are required to send skin specimens to pathologist for biopsies and surgeries).

I have read and fully understand the above consent for treatment of biopsies and Benson Dermatology's financial policy.

Patient's Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____ Date: _____



BENSON
DERMATOLOGY

INTEGRATED DERMATOLOGY OF PONCHATOULA, LLC
PHONE: (985) 370-7546 **FAX: (985) 370-7765**

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No Show Policy:

In Consideration of other Benson Dermatology patients and the staff, please give at least a 24 hour notice of an appointment cancellation. If a patients fails to show for a scheduled appointment three times without at least a 24 hour notification, the patient will be dismissed from the practice.

Patient Name: _____

Patient/Legal Guardian Signature: _____

Date: _____