

**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 \_\_\_\_\_

# Benson Dermatology & Skin Cancer

**Patient Name:** \_\_\_\_\_

**Type of Visit:** \_\_\_ New \_\_\_ Follow-up

**Referred By:** \_\_\_\_\_

**Past/Present Medical History:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Pace maker/defibrillator |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Pregnant                 |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Rash                     |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Rheumatic fever          |
| <input type="checkbox"/> Bladder infections  | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Scarlet fever            |
| <input type="checkbox"/> Bleeding tendency   | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Shingles                 |
| <input type="checkbox"/> Cancer (skin/other) | <input type="checkbox"/> Measles               | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Chickenpox          | <input type="checkbox"/> Melanoma              | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Dementia            | <input type="checkbox"/> Migraine headaches    | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Venereal disease         |
| <input type="checkbox"/> Epilepsy/seizures   | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> 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:** \_\_\_\_\_



# INTEGRATED DERMATOLOGY GROUP, LLC

180 North 5<sup>th</sup> Street  
Ponchatoula, LA 70454

190 Greenbriar Blvd., Ste 103  
Covington, LA 70433

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

## 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 responsibility 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.

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Patient's Name:

Date:

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Signature of Patient or Legal Guardian:

Date:



**BENSON**  
**DERMATOLOGY**

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(985) 370-7546  
(985) 370-7765

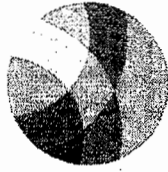
**No Show Policy:**

In consideration of other Benson Dermatology patients and the staff, please give at least a 24 hour notice of an appointment cancellation. If a patient 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: \_\_\_\_\_



# BENSON DERMATOLOGY

INTEGRATED DERMATOLOGY GROUP, LLC

PHONE: (985) 370-7546

FAX: (985) 370-7765

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## Credit Card Policy

As it has become the standard in medical practices, Benson Dermatology has implemented a credit card policy to help minimize health care costs for both our patients and office. At the time you check in, you will be asked for a credit card number and information which will be held **SECURELY** until your insurance(s) have paid their portion and notified our office of the amount you share. At that time, if your balance owed is \$100.00 or less, your credit card on file will be charged. If your balance exceeds \$100.00, your credit card on file will be charged \$100.00, and a statement will then be mailed to you with the remaining balance owed.

This will be an advantage to you, since you will no longer have to write and mail checks to our office for balances of \$100.00 or less. This policy will also be beneficial to our office, since it will decrease the number of statements generated and mailed to our patients.

**I AUTHORIZE BENSON DERMATOLOGY TO CHARGE OUTSTANDING BALANCES OF \$100.00 OR LESS ON MY ACCOUNT TO THE FOLLOWING CREDIT CARD:**

VISA/ MASTERCARD/ DISCOVER/ AM EX (CIRCLE ONE PLEASE)

Last Four of Account Number: \_\_\_\_\_ Exp date: \_\_\_\_\_

CVV code: \_\_\_\_\_ Billing Zip code: \_\_\_\_\_

Name On Card: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_