

Dermatologists of Southwest Ohio, Inc.

5300 Far Hills Ave
Dayton Ohio 45429
Patient Information

ACCOUNT NUMBER

Have you ever been seen by one of our physicians? Yes ___ No ___ Physician Name(s) _____

Office _____ Year _____

If your name has changed, your previous name: _____

Name: _____ M F S M W D
First Middle Last Sex Marital Status

Address: _____
Street City State Zip Code

() ()
Home Telephone Emergency Telephone Contact Name E-Mail Address

Age: _____ Date of Birth _____ Social Security No: _____ Race _____

Occupation: _____ Previous occupation if retired: _____

Employer Name: _____ Telephone _____

Place of employment or school: _____

Family Physician: _____

Person Responsible For Payment if Other Than Patient

Billing Name: _____ S. S. # _____ Date of Birth _____

Phone Number: _____

Street: _____ City: _____ State _____ Zip Code _____

Employer: _____

Relationship to Patient _____

How did you hear about us?

Physician Name _____

Friend _____ Insurance Company _____

Commercial Radio Newspaper Yellow Pages

Has any member of your family been seen here before? ___ Yes ___ No

Name of Family Member _____

Patient Name _____

Please show us your insurance card so we may make a copy of it for your chart

Does your insurance require a referral ___ Yes ___ No Name and address of referring Physician _____

Primary Insurance (1st Insurance)

Insurance (Primary) _____

Insurance Effective Date _____ Insurance Phone No: _____

Subscriber's Name and Address (if different from above) _____

Employers name _____

Subscriber's Policy Number _____ Group No. _____ Specialty Co-Pay _____

Subscriber's Date of Birth _____ Subscriber's Social Security # _____

Insurance (Secondary)

Insurance (Secondary) _____

Insurance Effective Date _____ Insurance Phone No: _____

Subscriber's Name and Address (if different from above) _____

Employers name _____

Subscriber's Policy Number _____ Group No. _____ Specialty Co-Pay _____

Subscriber's Date of Birth _____ Subscriber Social Security # _____

Insurance (Tertiary)

Insurance (Tertiary) _____

Insurance Effective Date _____ Insurance Phone No: _____

Subscriber's Name and Address (if different from above) _____ Subscriber's Date of Birth _____

Deductible Information

| | | |
|--|-----|----------|
| Do you have a high deductible plan | Yes | No |
| If yes, how much? | | \$ _____ |
| How much of deductible is met to date? | | \$ _____ |
| Do you have a health savings account | Yes | No |

Due to changes in insurance policies co-pays, deductibles and any amount not covered by insurance will be requested at the time of service or billed to the patient. This policy covers all physicians of the practice.

Insurance Authorization and Assignment

Authorization is hereby granted Dermatologists of Southwest Ohio, Inc., its medical staff, and other personnel to obtain and release to my insurance company and/or third party payor such information, including medical records, as may be necessary for the completion of my present and future treatment claims. I hereby assign to the physician(s) all payment for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by Insurance.

Signature of Responsible Party X _____ Date: _____

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Name _____ Date of Birth _____

Pharmacy _____ Pharmacy # _____

List all allergies including medication allergies:

List all health problems/Diseases, including Skin:

List all Medications you are currently taking, including non-prescription:

List all Family History of Medical Problems(Mother, Father, Siblings):

List Past Surgeries and Year:

Have you tested positive for Tuberculosis : yes _____ no _____

Do you smoke: Yes _____ No _____ if yes how much _____ pack/day

Smokeless Tobacco: Yes _____ No _____ if yes how much _____ per/day

Alcohol Intake: _____ weekly

Other _____

Signature of Responsible Party _____ Date _____

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Dear Patient,

Thank you for choosing Dermatologists of Southwest Ohio. The following is our financial policy. Please review the policy initial where indicated and sign and date at the bottom.

Paperwork

We request you routinely update your paperwork to ensure we have the correct information on hand for billing purposes and to ensure excellent clinical care. This paperwork allows us to bill insurances in a timely manner preventing balances being unnecessarily transferred to you the patient. We understand the frustration of completing paperwork and are constantly evaluating different methods to reduce the burden on you.

Missed Appointments/ Cancellations

We request 24 hour advanced notification of cancellation and reschedules. We try to notify all patients of upcoming appointments using our computerized calling system. Unfortunately, we do experience errors with the system from time to time. We do not charge for missed appointments or cancellations. Frequently missed appointments and cancellations can result in dismissal from our practice.

Insurance

Our practice is contracted with most commercial insurances and Medicare. We currently do not accept Medicaid. As a contracted provider, we agree to accept adjusted fees from your insurance company and bill in accordance with CPT and ICD-9 guidelines. We collect co-pays at the time of visit. Deductibles and other outstanding balances will be billed to you, after your claim has been processed by your insurance company. We are unable to determine prior to your visit what charges will be applied to your deductible.

Available forms of payment include: cash, check, MasterCard and Visa.

Cosmetic Procedures

Payment is expected in full at the time of your procedure.

Lab Fee

Dermatologists of Southwest Ohio uses an outside laboratory for pathology services. When possible the practice will bill for the laboratory services.

Patient is Responsible for Total Charge

Patients will be billed in full for any unpaid copayments or deductibles. Patient balances will be set by the adjusted rates as determined by our contract with your insurance company. In accordance with our contracts and Medicare guidelines we cannot make adjustments to these fees or the codes charged. Prompt payment is expected.

Initial _____

Recent insurance policy changes and the popularity of high deductible plans have increased the number of bills and balances to patients. If you have not met your deductible for your plan year, please expect a bill from our office. Per our insurance contracts we are unable to make adjustments to any outstanding balance.

My signature below indicates I have read and agree to the above written financial policy of Dermatologists of Southwest Ohio

Signature of Patient/Guardian