Dermatology Associates of Northern Virginia, Inc.

Account # _____

Medicare Patient Information

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name: _____ ,_____ ,_____ "_____"
Last *First* *M.I.* *Nickname*

Date of Birth: ____/____/____ Age: _____ Sex: M / F

As Mandated by Federal Government and Meaningful Use Criteria:

Race _____ Ethnicity _____ Preferred Language _____

Tobacco Use: NO YES If yes, smoker or smokeless tobacco (circle one)

Referring Physician _____, _____
Doctor's Name Phone Number

CONTACT INFORMATION: Check preferred contact number

Mailing Address: _____, _____ _____
City State Zip

☐ Home Phone: _____

☐ Cell Phone: _____ Email: _____

ARE YOU INTERESTED IN RECEIVING OUR E-NEWSLETTER? YES NO

EMERGENCY CONTACT

Name:_____Relationship:_____

Phone #_____ Alternative Phone #_____

INSURANCE COVERAGE

Medicare ID Number (Social Security Number): _____

Secondary Insurance Carrier: _____ ID#: _____ GROUP#: _____

Name of Policy Holder _____ Relationship to Patient: _____

Policy Holder Date of Birth: ____/____/____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

_____ _____ Date_____/_____/_____
Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

PATIENT COMMUNICATION AUTHORIZATION

If you anticipate that you will need or want your medical information provided to family members, friends or caretakers/babysitters please indicate below. If you do not want any of your medical information provided to a family member please check no.

Spouse:_____ _____yes _____no

Child:_____ _____yes _____no

Other:_____ _____yes _____no

_____ _____ Date_____/_____/_____
Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

CONTINUED INFORMATION ON BACK

Please Sign So We May Have Your Medicare Authorization On File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: _____/_____/_____ Signature: _____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: _____/_____/_____ Signature: _____

Payment Policy

Medicare: **We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees. In the event that an appointment is not cancelled within 24 hours, you will be charged up to a $50.00 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date _____/_____/_____

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).
I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.
A copy of this authorization may be used in the place of the original.
I understand and agree that I am financially responsible for all charges not paid by my insurance company.
This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature _____ Date _____/_____/_____

I understand that in certain circumstances Medicare may decide that appropriate medical services are not medically reasonable or necessary under the Medicare law. I agree to be personally responsible for payment of these charges.

Patient or Responsible Party Signature _____ Date _____/_____/_____

Please stop by after your appointment to let us know how your experience was today by filling out a review form located in the waiting room.