Iberia Dermatology

REGISTRATION

Name_____ Age_____ Date of Birth____/____/_____
First Middle Last

Mailing Address_____ Home Phone_____
Street City,State Zip

Employer_____ Occupation_____ Work Phone_____

Social Security#_____-_____-_____ Sex ☐M ☐F Cell Phone_____

Person responsible for account if patient is a minor_____

If you are insured under a different person (such as a parent, spouse, or guardian), please fill out that policyholder's information:

Policyholder Name_____ Policyholder Social Security# ___-___-____

Policyholder date of birth____/____/_____Relationship to patient ☐child ☐spouse ☐other_____

Policyholder Address_____
Mailing Address City State Zip

As a courtesy to you, if the doctor participates in your insurance plan, we will file your insurance for you. It is *your* responsibility to verify that your doctor is on your plan. We cannot *guarantee* payment by your insurance company. If your insurance company does not cover your visit, you are responsible for paying your charges.

Please note that any elective or surgical procedures to remove skin tags, moles or cysts will be sent to a pathologist for a complete medical diagnosis. Your insurance information will be forwarded and you may be billed separately by the laboratory.

Your payment, deductible, and/or copay, are due at the time of service. We currently accept cash or checks. If you do not have cash or a check, we will accept credit cards for a nominal service charge.

If we are not a participating provider in your insurance plan, you will be given a receipt to send to your insurance company, in the event that they may reimburse you.

You will be charged half of the procedure cost if you miss your elective surgery, Botox, chemical peel, or sclerotherapy appointment without 48 hours prior cancellation.

There will be a $30.00 service charge on any NSF ("bounced") check, in the event that your account becomes delinquent, you will be responsible for additional delinquent fees up to 50% of remaining balance, interest (1%), attorney fees and/or court cost incurred as a result of non-payment of the debt.

I understand and accept these policies, and I understand that I am financially responsible for all charges, whether or not they are paid by my insurance company. I authorize i.) the release of any medical information to my referring physician and insurance company so that my insurance claim may be processed; and, ii.) payment of medical benefits to Iberia Dermatology.

I have read and agree to the policies in the Notice of Privacy Practices version 3.1.03 and understand that I may have a copy of it should I request one. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations.

Circle one:

_____ Parent/ Self/ Guardian _____/_____/_____

Signature **Date**

(A guardian's signature is required if a patient is under 18 years old.)

Please present your insurance cards and photo ID (driver's license) to our receptionist.

Thank you and welcome to the practice.