

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Today's Date ____/____/____

Name: _____
Last First Middle Initial

Date of Birth: ____/____/____ Age: ____ Social Security #: _____ Sex: Male Female

Mailing Address _____

Home Phone: () _____ Other: () _____
City State Zip

Patient's Occupation: _____ Work Phone: () _____ Ext: _____

Email address: _____

Marital Status: Single Married Divorced Widowed Separated

RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First Middle Initial

Address: _____
City State Zip

Home Phone: () _____ Work Phone: () _____

Date of Birth: ____/____/____ Social Security #: _____ Sex: Male Female

INSURANCE COVERAGE – PRIMARY

Insurance Co. Name: _____ Phone: () _____ Ext: _____

Address of Claim Center: _____

Name Policy Holder (Insured): _____ Date of Birth: ____/____/____
City State Zip

Policy #: _____ Group Name or #: _____

Policy Type: HMO PPO Employer Name: _____

Employer Address: _____

If patient is a child, check relationship: Mother Father Other _____

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name: _____ Phone: () _____ Ext: _____

Address of Claim Center: _____

Name Policy Holder (Insured): _____ Date of Birth: ____/____/____
City State Zip

Policy #: _____ Group Name or #: _____

Policy Type: HMO PPO Employer Name: _____

Employer Address: _____

If patient is a child, check relationship: Mother Father Other _____

REFERRED BY: _____

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Today's Date ____/____/____

Other family members that are patients _____

Referred by: _____ Primary Care Physician: _____

In case of Emergency, who should be notified? _____ Phone: () _____

Please be advised: Charles E. Crutchfield III, MD is a Clinical Associate Professor of Dermatology at the University of Minnesota. Often times, he will have a physician or student physician following him. We will be sensitive and accommodating to your concerns. If you are uncomfortable with this, please inform your nurse.

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

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

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 \$100.00 deductible and paying for the 20% 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 billed the remaining balance.

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.

HMO, PPO or other managed care patients and all other patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic/medical services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35 % of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

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

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers of Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a 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.

Signature as it appears on Medicare Card _____ Date ____/____/____

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature 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.

Signature as it appears on MEDIGAP Card _____ Date ____/____/____