Gerald W. Newman, M.D.

Dermatology and Dermatologic Surgery Associates

Please present your insurance card(s) and photo ID. The receptionist will make a copy and return them to you promptly. If you have been referred by a physician, please submit any referral documentation. Thank you.

Patient Information:

Name_____Date of Birth ____/____/____Age_____
Last Name First Name Middle int.

Address_____
Street Address City State Zip Code

Home Phone _____Work _____ext_____ Cell_____

Sex: M F Marital Status: Married Single Divorced Widowed

Social Security # _____-_____-_____ E-mail Address_____
*Used for practice update information and practice promotions only

Parent or Responsible Party *(if different from patient)*

Name_____Date of Birth ____/____/____ Age_____
Last Name First Name Middle int.

Address_____
Street Address City State Zip Code

Home Phone _____Work _____ext_____ Cell_____

Social Security # _____-_____-_____ E-mail Address_____
*Used for practice update information and practice promotions only

Referral Information:

Referred by _____ Doctor Friend Family Other

Primary Care Physician_____

Other family members that are patients:_____

Pharmacy Information:

Pharmacy Name: _____

Street:_____ City:_____Zip code:_____

Pharmacy Phone #:_____ Pharmacy Fax #: _____

Initials: _____ **Date:** ____/____/____

Insurance Information:

Primary Insurance Company_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Policy Holder Relationship to Patient: Self Spouse Other _____

Secondary Insurance Company_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Policy Holder Relationship to Patient: Self Spouse Other _____

Release Information:

I authorize you to leave a message regarding: (Check all that apply)

_____Medical Information _____Lab Results _____Billing Information

You may leave a message regarding above at the following phone numbers: (Check all that apply)

_____Home # _____Work # _____Cell #

I authorize you to discuss the following information with the persons listed below:

_____Medical Information _____Lab Results _____Billing Information

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

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**___/____/____

Emergency Contact Information:

In case of Emergency, who should be notified? _____

Relationship to Patient: _____ Phone : _____

Initials: _____ **Date:** ____/____/____

Payment Policies:

Office Financial Policy - In order to establish optimal relations with our patients and avoid misunderstanding or 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 that they are rendered unless you are in a prepaid plan with which we participate. Fees for cosmetic or other uninsured medical procedures are due prior to treatment. We accept payment in the form of cash, check, or credit card. Should your bank return any check to our office, a $25.00 returned check fee will be charged to your account. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. You may be charged a fee for copies of your medical records.

Medicare – We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $130.00 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 balance billed.

PPO and Managed Care Patients – You will be responsible for paying your annual deductible, co-payment and charges for any non-covered and cosmetic services. Co-payments and deductibles that are due will be collected at the time of the visit. You will be responsible for providing and maintaining referrals to our office if required by your insurance plan.

Commercial Patients – Patients who are covered by private, commercial plans in which our physician is not a provider will be required to pay the total charges at the time of service. However, we will submit the paperwork to your insurance on your behalf to assist with any reimbursements available to you.

Patient or Responsible Party Signature_____ _____**Date** ____/____/____

Receipt Notice of Privacy Practices

I, _____, have received a copy of Dermatology & Dermatologic
Print Name Here

Surgery Assoc.'s Notice of Privacy Practices.

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 Health Care Financing Administration 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**____/____/____