Marianne W. Rosen, M.D. & Associates, LLC

PATIENT INFORMATION

(PLEASE PRINT)

DATE: _____

PATIENT NAME: _____ / _____
(LAST) (FIRST) (MIDDLE) (PREFERRED NAME)

STREET ADDRESS: _____

_____
(CITY) (STATE) (ZIP CODE)

BILLING ADDRESS:_____
(IF DIFFERENT THAN ABOVE)

BIRTHDATE: _____ SEX: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____

OCCUPATION: _____ REFERRING PHYSICIAN: _____

MARITAL STATUS: MARRIED SINGLE OTHER RACE: _____

PHONE #'S: HOME: _____ WORK: _____ CELL: _____

EMAIL ADDRESS: _____

SPOUSE OR PARENT INFORMATION (IF MINOR OR STUDENT)

SPOUSE OR PARENT NAME: _____

SPOUSE OR PARENT BIRTHDATE: _____ SS#: _____

SPOUSE OR PARENT EMPLOYER: _____

SPOUSE OR PARENT WORK PHONE: _____ CELL: _____

INSURANCE INFORMATION

(COPY OF INSURANCE CARD IS REQUIRED)

PRIMARY INSURANCE: _____

INSURED'S FULL NAME: _____

INSURED'S BIRTHDATE: _____ INSURED'S SS#: _____

INSURED'S EMPLOYER: _____ PHONE#: _____

SECONDARY INSURANCE: _____

INSURED'S FULL NAME: _____

INSURED'S BIRTHDATE: _____ INSURED'S SS#: _____

INSURED'S EMPLOYER: _____ PHONE#: _____

CONSENT FOR TREATMENT

I, the undersigned patient or my authorized representative, hereby authorize: Marianne W. Rosen, M.D. and whomever she may designate as her assistant, covering physician or locum tenens to render my medical treatment to me. I consent to the medical care, which encompasses laboratory, diagnostic, surgery or medical treatment, which they may deem necessary.

PATIENT SIGNATURE: _____ DATE: _____
(PARENT SIGNATURE IF PATIENT IS A MINOR)

PATHOLOGY

I, the undersigned patient, understand that I will receive a separate bill from the pathologist for any specimens that may be sent out for pathology. This is a necessary part of my treatment to diagnose any lesions that may be removed during my visit.

PATIENT SIGNATURE: _____ DATE: _____
(PARENT SIGNATURE IF PATIENT IS A MINOR)

SOCIAL SECURITY ADMINISTRATION

*(If you do **not** have Medicare, please skip this section)*

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 carriers 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 to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

PATIENT SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time the services are rendered unless payment arrangements have been approved in advance. Necessary information will be supplied to you to enable you to file your insurance for plans we are not contracted with. Deductibles and copayments will be collected at the time services are rendered. We accept cash, check, Visa, MasterCard, Discover and American Express. We will be happy to file your insurance claim for reimbursement and in most cases we accept assignment of insurance benefits. Returned checks are subject to a $35.00 return check fee.

*Please note that we charge **$25.00** for missed or no-show appointments. We also charge **$50.00** for biopsy or surgery appointments that are not cancelled or re-scheduled within 2 business days prior to the appointment because of our inability to fill the time slot with a patient in need of medical care.*

You must understand:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is **your responsibility** to make sure that we are in-network with your plan PRIOR to your appointment.
- Not all services are a covered benefit on all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- If you are covered by an HMO, you are required to have an approval (in hand or faxed to our office) provided by your primary care physician or you will have to reschedule your appointment. This authorization is needed on **the day of your visit** for your services to be covered by your HMO. Some HMO's require pre-authorization for test(s) the doctor may order. You are required to ensure that the authorization has been obtained BEFORE the test(s) are performed.
- If your insurance company requires that tests (i.e. lab test, cultures, pathology specimens, etc.) be sent or performed at a certain hospital/lab, it is **your responsibility** to inform us of that at the time these tests are performed or ordered. Otherwise, Dr. Rosen will order tests or send specimens to the hospitals/labs of her choice. You will receive a separate bill from them.
- If we do not receive payment on your unpaid balance in a timely manner, your account may be sent to a collection agency and if so, possibly reported to the credit bureaus. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You also authorize and consent to us providing your contact information to any third-party for the express purpose of collecting any amounts you may owe this practice. You agree to pay any and all collection agency fees, which are based on a percentage of your debt and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

PATIENT SIGNATURE_____ **DATE:** _____

(PARENT/LEGAL GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company or any third party that may be involved such as an attorney and/or liability insurance carrier. **While the filing of insurance claims is a courtesy that we extend to our patients, all fees are ultimately the patient's responsibility to pay**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We are here to help you.

PATIENT SIGNATURE: _____ DATE: _____
(PARENT/LEGAL GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

INSURANCE AUTHORIZATION

I authorize the release of any medical or other information necessary to process insurance claims for services rendered. I also request payment of medical benefits to the undersigned physician or party who accepts assignment.

PATIENT SIGNATURE: _____ DATE: _____
(PARENT SIGNATURE IF PATIENT IS A MINOR)

TO OUR PATIENTS

Our contracts with your insurance companies **require** us to collect your deductible, co-pay or coinsurance amounts from you at the time of service. Please do not ask us to provide a discount for our services or to waive these payments.

In addition, State Law Chapter 55, Section 38-55-170 lists the substantial penalties including fines with incarceration that result in filing false claims with insurance companies. In an opinion written by Attorney General Charlie Condon, he states that 'billing "insurance only" or waiving coinsurance or co-pays is filing a false claim and the practice and doctors doing so are subject to the above penalties.'

If you feel you will have trouble meeting your financial responsibilities, please ask to speak with our Office Manager.

Thank you for your cooperation.

Date: _____ Name: _____

Review of Symptoms (Circle if any problems with)

Eyes

Ears

Nose, Sinuses

Teeth

Heart (MV prolapse, murmur, pacemaker)

Lungs

Gastrointestinal (stomach)

Musculoskeletal (joint replacement)

Neurologic, Psychiatric

Thyroid, Endocrine

Blood, Lymphatic

Allergic, Immunologic

Skin, Skin Cancer, Many Moles

Genital, Urinary (Are you pregnant?)

Family History (Circle if any applies to any family member)

Skin Cancer

Melanoma

Skin Disease (psoriasis, eczema, lupus)

Major Illness

Past History (Please list)

Operations _____

Major Illness _____

Drug Allergies _____

Current Medications _____

Social History (Short Answers)

Occupation _____

Tobacco Use_____

Alcohol Use _____

Sunscreen Use _____

Past Blistering Sunburn _____

Frequent Sun Exposure _____