Marianne W. Rosen, M.D. & Associates, LLC **Date:** _____

PLEASE PRINT - PATIENT INFORMATION ID#_____

PATIENT NAME: _____/_____
(TITLE) DR / MR / MRS / MISS (LAST) (FIRST) (MIDDLE) (PREFERRED NAME)

STREET ADDRESS: _____

_____ **DATE OF BIRTH**:_____ **SEX:** _____
(CITY) (STATE) (ZIP CODE) (MONTH/DAY/YEAR)

BILLING ADDRESS: _____
(IF DIFFERENT THAN ABOVE)

SOCIAL SECURITY #: _____ **REFERRING PHYSICIAN:** _____
(NAME & NUMBER)

CIRCLE PREFERRED CONTACT# HOME: _____**WORK:**_____**CELL:** _____

CAN WE LEAVE TEST RESULTS ON YOUR VOICEMAIL? ☐YES ☐NO

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐LEGALLY SEPERATED ☐WIDOWED

RACE: ☐DECLINED TO SPECIFY ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐HAWAIIAN/PACIFIC ISLANDER

☐BLACK OR AFRICAN AMERICAN ☐WHITE ☐HISPANIC OR LATINO ☐OTHER _____

OCCUPATION: _____**EMPLOYER:** _____ **PREFERED LANGUAGE:**_____

EMERGENCY CONTACT: _____**RELATIONSHIP TO PATIENT?** _____
(NAME & NUMBER)

DO WE HAVE PERMISSION TO DISCUSS YOUR MEDICAL HISTORY WITH ANOTHER PERSON? ☐YES ☐NO

IF YES, PLEASE LIST THAT PERSONS NAME & PHONE NUMBER: _____

PATIENT EMAIL : _____
@GMAIL.COM @OUTLOOK.COM @MAC.COM @YAHOO.COM @ME.COM @AOL.COM @MSN.COM

DO YOU AUTHORIZE OUR OFFICE TO SEND YOU PROMOTIONAL EMAILS TO THE ADDRESS ABOVE? ☐YES ☐NO
(THESE EMAILS ARE **NOT** SHARED WITH ANYONE, AND ONLY SENT OUT WHEN WE ARE HAVING PROMOTIONS ON PRODUCTS/SERVICES.)

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 AND/OR MY MINOR CHILD (IF PATIENT IS A MINOR). I CONSENT TO THE MEDICAL CARE, WHICH ENCOMPASSES LABORATORY, DIAGNOSTIC, SURGERY OR MEDICAL TREATMENT, WHICH THEY MAY DEEM NECESSARY.

PATIENT/PARENT SIGNATURE: _____ **DATE:** _____

INSURANCE INFORMATION

(A COPY OF PATIENT INSURANCE CARD & DRIVERS LICENSE IS REQUIRED)

IS PATIENT THE POLICY HOLDER OF HEALTH INSURANCE? ☐YES ☐NO

PRIMARY INSURANCE COMPANY: _____

INSURED'S FULL NAME: _____ MEMBER ID#_____

SECONDARY INSURANCE: _____

INSURED'S FULL NAME: _____MEMBER ID#_____

IF YOU SELECTED NO ABOVE, WE MUST HAVE THE FOLLOWING INFORMATION:

SPOUSE or PARENT'S NAME: _____**DATE OF BIRTH:** _____
(IF PATIENT IS A MINOR) (MONTH/DAY/YEAR)

SPOUSE or PARENT SSN#_____ **CELL:** _____

SPOUSE or PARENT EMPLOYER: _____ **WORK PHONE:** _____

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)

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 biopsies, surgeries, and cosmetic appointments that are not cancelled or re-scheduled at least 24 hours prior to the appointment.** Less than a 24-hour cancellation, does not give us adequate **time** to fill the time slot with a patient in need of medical care. Your insurance company will **NOT** cover this fee.

Please understand:

- 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 YOU DO NOT HAVE PROOF OF THE AUTHORIZATION, YOU MAY BE RESPONSIBLE FOR 100% OF ALL OFFICE VISIT FEES & LAB FEES.)**
- If your insurance company requires 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 these requirements at the time these tests are performed or ordered. Otherwise, Dr. Rosen will order tests/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 will be sent to a collection agency automatically after 120 days, and possibly reported to the credit bureaus.** You agree to reimburse Marianne W. Rosen, MD & Associates, LLC the fees of any collection agency, which may be based on a percentage of your debt at a maximum of 40% and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

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.** 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/ incarceration for filing false claims with insurance companies.**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our Office Manager for assistance in the management of your account.

PATIENT SIGNATURE: _____ DATE: _____

(PARENT SIGNATURE IF PATIENT IS A MINOR)

Please check any current issues/concerns:

☐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/Unusual Moles/Rash

☐Genital/Urinary

Are you pregnant or possibility of? ☐Yes ☐ No

Are you nursing? ☐ Yes ☐No

Family History of:

☐Skin Cancer

☐Melanoma

☐Skin Disease (Psoriasis, Eczema, Lupus)

☐Major Illness

Past Medical History (Please list)

Skin Cancer: _____

Previous Operations: _____

Major Illnesses: _____

Drug Allergies: _____

Frequent Sun Exposure: ☐ Yes ☐ No

History of tanning bed usage: ☐ Yes ☐ No

Tobacco Use: ☐Yes ☐No

Do you use Sunscreen: ☐Yes ☐ No

Past Blistering Sunburn: ☐Yes ☐No

Alcohol Use: ☐Yes ☐No

Patient Signature: _____ **Date: _____**

(PARENT SIGNATURE IF PATIENT IS A MINOR)