□ 7881 Carnegie Blvd, Fort Wayne □ 11635 Coldwater Road, Fort Wayne □ 815 High St, Decatur □ 3505 N. State Rd 15 Suite C, Warsaw

PLEASE ARRIVE 15 MINUTES PRIOR TO APPOINTMENT

Appt: Date_____ at_____

□ Hentz □ Helsom
□ Sarkisian □ Baker
□ McGovern □ Giarmo
□ Hobbs □ Wampler
□ Bernardi □ Jones
□ Shoda

ACCOUNT NO. _____ Today's Date_____

PATIENT INFORMATION

Patient's Name _____ SSN _____

Address _____ Preferred Phone_____

E-mail address_____ Alternate Phone _____

Sex _____ Marital Status_____ Age _____ Date of Birth _____

Family Dr. _____ City _____ Referring Dr. _____ City_____
(first and last name) (first and last name)

If patient is minor, with whom does patient live? Please list to whom patient's mail should go to first:

Name _____ Relationship to Patient: Father, Mother, Other_____

*It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.

Primary Insurance Company: _____ Insurance through an employer? Y N

If yes, Insured's Employer _____ Employee's Name:_____

Insured's Date of Birth: _____ Insured's SSN_____

Insured's Address (If different) _____ Home Phone _____

Secondary Insurance Company_____ Insured's Employer_____

Insured's Name _____ Date of Birth_____ SSN_____

Insured's Address (If different) _____ Home Phone _____

Whom may we contact in case of an emergency?_____

Relationship _____ Phone _____

PATIENT FINANCIAL RESPONSIBILITY – IMPORTANT – PLEASE READ CAREFULLY

I acknowledge and agree that I am ultimately responsible for the costs of all professional medical services rendered by Fort Wayne Dermatology Consultants, Inc., its physicians and employees (collectively "FWDC"). Any balance for professional medical services which are 60 days overdue is subject to a $10 rebilling fee. I certify that the information provided below is true and correct to the best of my knowledge and I will notify FWDC of any changes in my health status, insurance coverage, or address.

I acknowledge and agree that I am responsible to pay all fees and professional medical services provided by FWDC to me, my minor child or other dependent, unless FWDC has a written agreement with my insurance plan which provides that FWDC will accept an agreed upon fee for services.

I further acknowledge and agree that even if my insurance plan does not pay for every professional medical service that is provided by FWDC that I will be ultimately responsible for the costs of those professional medical services. Even if my insurance plan denies payment for these professional medical services because the insurance plan does not consider them medically necessary, I still will be responsible to FWDC for all costs incurred. I further agree and acknowledge that all professional medical services and procedures that I receive from FWDC have been requested by the undersigned with the full knowledge that my insurance plan may not cover all of the expense for those medical services.

As a patient of Fort Wayne Dermatology Consultants, Inc., it is the responsibility of the patient to know what is covered by his/her insurance. To better serve you, we may send out tissue to another lab for diagnosis, additional stains, and/or second opinion. All cultures (bacterial, viral, fungal, etc.) are sent out to LabCorp for processing and diagnosis. By signing below, you are stating you have been informed and are responsible for the payment of the above services.

We do our best to get accurate charges at the time of service. However, during our coding audit if we find charges that were inadvertently left off your bill, these charges will be sent to your insurance and/or billed out.

I agree that I have read this and that I understand it.

Signature: _____ Date _____

Parent Signature (for minor): _____ Date: _____

Social Security No.: _____

INSURANCE AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize Fort Wayne Dermatology Consultants, Inc. to furnish information to my insurance carrier concerning my illness and/or treatment. I may at any time revoke this authorization, and it will remain valid until I revoke it.

Signature: _____ Date: _____

Parent Signature (for minor): _____ Date: _____

FOR MEDICARE PATIENT ONLY:
STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Fort Wayne Dermatology Consultants, Inc., including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits for related services.

Signature: _____ Date: _____

Parent Signature (for minor): _____ Date: _____