Andrus & Associates Dermatology
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Patient Information (Please Print) Account

Patient Name_____ **Sex** ☐ M ☐ F **Marital Status** ☐ S ☐ M ☐ D ☐ W
First M.I. Last Name

Address_____ **Date of Birth**___/___/_____ **Age**_____

City_____ **State**_____ **Zip**_____ **Social Security #**_____

Telephone Numbers: Home_____ **Mobile**_____ **Work**_____
We will attempt to contact you at the "Home" number to remind you of your appointments. If you prefer to be reminded at one of the other numbers, please circle the number. We will leave the reminder on your answering machine/voice mail if you are unavailable.

Occupation_____ **Employer & Address**_____

Primary Insurance_____ **Secondary Insurance**_____

Referred by Dr._____ **Referring Dr.'s Address**_____
First Last

Primary Care MD_____ **Family members who are patients** _____

In case of emergency, notify_____ **Telephone**_____

Spouse's Name or Parents'(if minor)_____ **Telephone**_____

If covered by Spouse's/Parent's insurance policy, list policyholder's SS#_____ **& DOB**___/____/_____

Spouse's/Parents' Address, ***if different from yours***_____ **City**_____ **State**_____ **Zip**_____

Spouse's/Parent's Employer_____ **Work Telephone**_____

Employer's Address_____ **City**_____ **State**_____ **Zip**_____

Have you ever had the following medical problems? Check all that apply.

☐ Cancer-type/location_____ ☐ Heart Disease ☐ High Blood Pressure ☐ Liver Disease

☐ Diabetes ☐ Heart Surgery ☐ Heart Valve Replacement ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C

☐ Glaucoma ☐ Pacemaker ☐ Joint Replacement ☐ Tuberculosis/Positive TB Test

PLEASE INFORM THE DOCTOR IF YOU ARE PREGNANT OR NURSING.

List other health problems and surgeries_____

Drug Allergies ☐ Yes ☐ No Please list

Current Meds List (list aspirin if taken regularly)_____

Reason for Visit_____ /_____ /_____
Signature of Patient or Representative **Date**

PAYMENT POLICY

WE ARE REQUIRED BY LAW TO HAVE THESE SIGNATURES ON FILE

MEDICARE PATIENTS:
We do not participate with or file claims to the Medicare Advantage Plans (private Medicare plan options). We require payment at the time of service if you are covered by a Medicare Advantage Plan.
We are participating providers with the standard Medicare program, accepting assignment on all claims. You will be asked to sign an Advanced Beneficiary Notice for non-covered services. The ABN will explain your financial responsibility if you decide to proceed with the services. Patients are responsible for meeting their calendar-year annual deductible and paying the 20% copayment. Medicare automatically files most secondary insurance plans. If your secondary insurance does not automatically "crossover", we will supply you with an itemized statement to use for filing after receiving your explanation of benefits from Medicare. If your secondary does not pay to us within 60 days, you will be billed for the balance.

HMO, PPO OR OTHER MANAGED CARE PATIENTS:
You will be responsible for paying your annual deductible, copayment, coinsurance and charges for non-covered, cosmetic services.

COMMERCIAL PATIENTS:
Patients covered by private, commercial plans for which our physicians are not contractual providers will be required to pay at the time of service or a minimum of $100. Payment of any remaining balance will be billed and payable within 30 days. We will furnish an itemized statement for your use in filing a claim to your insurance company.

I have read and agree to adhere to the payment policies described above.
Signature of
Patient or Responsible Party_____**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 payor 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 to either myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature *as on your 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 on your Medigap Card*_____**Date**_____