Brummitte Dale Wilson, M.D. & Associates

ADULT & PEDIATRIC DERMATOLOGY & DERMATOLOGIC SURGERY

Patient Information Form

Welcome to Our Office! *Please Print & Answer* **ALL** *Questions* Date: ____/____/_____

How did you hear about us?	☐ Family _____	☐ Friend _____	☐ Local Edge Phone Book	☐ Close to Home/Work
	☐ Dr. _____	☐ Insurance plan _____	☐ Verizon Yellow Pages	☐ Other _____

PATIENT

Last Name: First: MI:			S.S. #	Marital Status: S M W D Sep	Sex: M F	Birth Date:	Age:
Address:			Name of ☐ Spouse ☐ Parent ☐ Guardian *(check one)*:			Email Address:	
City:	State:	Zip:	Home Phone # ( )	Cell Phone # ( )		Other # *(please specify)* ( )	
Occupation (indicate if student):			For how long?	Patient's Employer:			
Employer Address:			*City*	*State:*	*Zip:*	*Employer Phone:* ( )	

PERSON RESPONSIBLE FOR PAYMENT: (MUST BE PRESENT AT EACH VISIT)

☐ Patient or ☐ Name: _____ Policy Holder Date of Birth ____/____/_____

Relationship: ☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Legal Guardian ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Home Phone # ( ) _____

Employer Name: _____ Employer Phone: ( ) _____

PHOTO ID

Please provide Photo ID at your initial visit, or any time your ID has been updated.

A copy of the ID you provide will be retained so we may verify your identity at each visit.

☐ **Driver License** - Name _____ ID # _____ State _____ Exp Date ____/____/_____

☐ **Passport** - Name _____ ID # _____ Exp Date ____/____/_____

☐ **State / Government Issued** - Name _____ ID # _____ State _____ Exp Date ____/____/_____

☐ **Other** – Issuer _____ Name _____ ID # _____ Exp Date ____/____/_____

For Minors: A Parent or Legal Guardian's ID is required a

PRIMARY DOCTOR: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax # ( ) _____

REFERRING DOCTOR: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Fax # ( ) _____

PHARMACY

Primary Pharmacy: Name: _____

Address: _____ City _____ State _____ Zip _____

Phone #: ( ) _____ Fax # ( ) _____

Secondary Pharmacy: Name: _____

Address: _____ City _____ State _____ Zip _____

Phone #: ( ) _____ Fax # ( ) _____

INSURANCE

Primary Insurance:	ID #	Group #
Name of Policy Holder:	Primary Insured's Date of Birth:	Relationship to Patient:
Secondary Insurance:	ID #	Group #
Name of Policy Holder:	Secondary Insured's Date of Birth:	Relationship to Patient:

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PATIENT'S INSURANCE COVERAGE STATEMENT: The provider (B.D. Wilson, M.D. & Associates) may seek payment from me (patient/guardian) for any service(s) if I advise the provider prior to the services that I have no insurance coverage, give the provider incorrect or incomplete insurance coverage information, fail to give a valid referral covering all dates of service within 5-7 days of any visit, or give an invalid referral. I further understand that I will be held responsible for any services provided to me under the above circumstances for my initial visit and/or any applicable future services.

MISSED APPOINTMENT POLICY: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. **If it is necessary to cancel your scheduled appointment, we require that you call one business day (Monday-Friday) in advance or you may be considered a "no-show".** No-shows inconvenience those individuals who need access to medical care in a timely manner and may prevent another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule. **To cancel or reschedule an appointment please call our office at (716) 648-2770**, if our office is closed, please leave a message (all messages are date/time stamped).

Patients who no-show and fail to notify our office within at least one business day in advance, or show up more than 15 minutes past your scheduled appointment time, will be charged the following Fees:.

- **$150 Fee** for missed **Surgical** appointments
- **$50 Fee** for missed **Initial Visit**, **Follow Up**, or **Procedure** appointments
- **$25 Fee** for **all other** missed appointments not mentioned above

These fees are not reimbursable by insurance and are to be paid by the patient prior to scheduling their next appointment.

OFFICE PAYMENT POLICIES:

1. Insurance Co-Payments must be paid at EACH visit. ***Failure to pay co-pays will result in a $5 Billing Surcharge for each instance.***
2. If you have a deductible and your deductible hasn't been met, you will be asked to pay up to the amount of your unmet deductible at your visit. For the major carriers (BCBS, Independent Health, Univera) we verify the status of your deductible online prior to your visit.
3. If we do not participate with your insurance company, or if your treatment is deemed cosmetic or otherwise medically unnecessary, payment will be due at the time of your visit. An itemized statement will be given to you so you can seek reimbursement from your insurance company if the procedure was medically necessary.
4. The patient or responsible party agrees to pay interest at an annual rate of 24 % (2% per month) on any balance over 120 days old (retroactive to the procedure date).
5. The patient or responsible party agrees that all accounts are due upon receipt of statement, and that if this account is turned over for collection to any third party, the patient or responsible party will pay all costs of collection in addition to his or her balance including (but not limited to): up to a 25% surcharge for collection agency or attorney fees; court costs; filing and service fees. The patient may also be discharged as a result.

Patient or Responsible Party's Signature: _____ Date:_____

(Your signature above verifies your agreement to the above Insurance Coverage Statement, Appointment Policy, and Office Payment Policy)

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I request that payment of authorized Medicare or Other Insurance company benefits be made to Brummitte Dale Wilson, M.D. & Associates, for all services furnished to me by that practice and its physicians. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payments be made to the aforementioned and authorizes release of medical information as provided on the claim necessary to payment. If item #9 of the CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown.

I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION (UNLESS REVOKED IN WRITING).

Name of Policy Holder: _____

Signature: _____ **Date:** _____

<u>If you have Medicare and/or Secondary Insurance please read and sign below</u>:

I authorize payment of supplemental benefits from my insurance company to Brummitte Dale Wilson, M.D. & Associates for all services provided. I authorize the release of any information needed for processing of this or any related claim. I will permit a copy of this authorization and the Explanation of Medical Benefits (EOMB) to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION (UNLESS REVOKED IN WRITING).

Signature: _____ **Date:** _____