Date:_____
OFFICE USE ONLY

Columbus Skin Surgery Center inc.

PATIENT INFORMATION (Please Print)

Patient Name_____
Last First (Prefer to be called) MI

_____ - _____ - _____
Social Security Number

Address:_____
Street Apt., PO Box City State Zip

_____ - _____ - _____
Date of Birth

E-mail Address: _____ ☐ Female ☐ Male

Bill to *(if different from above)*:_____
Street Apt., PO Box City State Zip

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____

Race (optional): ☐American Indian ☐Asian ☐Native Hawaiian ☐African American ☐Caucasian ☐Hispanic ☐Other Race

Primary Language _____ Marriage Status_____ Employer Name _____

Responsible Party *(if patient is under 18 or POA)*

Name _____
Last First (Prefer to be called) MI

Mailing Address:_____
Street Apt., PO Box City State Zip

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____

Pharmacy Name _____ Phone _____

Pharmacy Address_____
Street Apt., PO Box City State Zip

Emergency Contact _____ Phone _____

Referred by _____ Phone _____

Primary Care Physician_____ Phone _____

Address:_____
Street City State Zip

Is there any physician other than your referring physician that you wish to have medical information sent to? If so please list below:

Physician Name_____ Address_____

Insurance Information ***(Please present insurance card at the time of check-in)***

Primary Insurance Name_____
Insurance Address _____
Insured's Name _____
Insured's Date of Birth _____ / _____ / _____ Sex ____
Insured's ID#_____
Group #_____
Employer Name _____
Relationship of patient to Insured _____

Secondary Insurance Name _____
Insurance Address_____
Insured's Name _____
Insured's Date of Birth _____ / _____ / _____ Sex ____
Insured's ID# _____
Group # _____
Employer Name _____
Relationship of patient to Insured_____

PLEASE TURN SHEET OVER —>

Precertification & Financial Responsibility: I understand that the insurer will review the planned course of treatment and make a determination regarding the medical necessity of the services and then issue certification of my plan benefits. We make every effort to inform you when precertification is required, however, due to multiple payer rules among the plans with which we participate, it is impossible for us to always know which services are payable according to your insurance company's policy. For services we are aware require precertification we will work with you to ensure that is secured. If precertification is late, refused or denied at any time, then payment for services is the responsibility of the patient or financially responsible person(s).

I have read and understand the above consent (Initials) _____

Assignment of Benefits: I assign and transfer to Columbus Skin Surgery Center, CSSC, all medical provider benefits related to the services rendered. I authorize and direct the insurance carrier to pay all benefits to CSSC. I understand that I am responsible for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and CSSC.

I have read and understand the above consent (Initials) _____

Consent to Release Claims Information: I hereby authorize Columbus Skin Surgery Center, its employees and agents to release all information concerning my (or the patient's) medical care and treatment for the purpose of treatment, health care operations and for claims payment, as provided for in the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may request restrictions to the uses of my information with written notice. I also understand that restrictions to the use of my information for the purposes outlined in this paragraph are subject to agreement by the CSSC.

I have read and understand the above consent (Initials) _____

I HAVE READ THE FRONT AND BACK OF THIS FORM AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, AND ASSIGNMENTS PRINTED AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

_____
Patient's Printed Name

_____ _____
Signature of Patient Date

I am legally authorized to provide consent on behalf of the patient listed above.

My relationship to the patient is described as follows:

_____
Signature of Authorized Representative

_____ _____
Relationship to Patient Witness