Clearline DERMATOLOGY

PATIENT INFORMATION UPDATE

First Name:_____ **Last Name**:_____ **MI**:_____

1) Please provide your current address and phone number

Address	_____ Street	_____ City/State	_____ Zip Code
Telephone	_____		

Since your last visit to our office:

2) Has your insurance changed? **Yes** ☐ **No** ☐

If 'Yes', please update your information.

Primary ☐ **Secondary** ☐	_____ Insurance Carrier	_____ Policy #
Policy Holder:	☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other:_____	

PLEASE INITIAL ON EACH LINE AFTER EACH SECTION

AUTHORIZATIONS

_____ ***(initial)*** I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to CLEARLINE DERMATOLOGY, LLC. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa™, or Mastercard™. In the event of major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your initials below communicate your understanding and willingness to comply with this policy.

_____ **PATIENT SIGNATURE** (or LEGAL GUARDIAN)

_____ **Date of Birth** *(mm/dd/yy)*

_____ **Date** *(mm/dd/yy)*

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SOCIAL SECURITY ADMINISTRATION

*(If you **DO NOT** have Medicare, please skip this section)*

_____ ***(initial)*** 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. I request that payment of authorized Medicare benefits be made either to me or on my behalf to CLEARLINE DERMATOLOGY, LLC for any services furnished to be by CLEARLINE DERMATOLOGY, LLC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____ _____

PATIENT SIGNATURE (or LEGAL GUARDIAN) **Date of Birth** *(mm/dd/yy)* **Date** *(mm/dd/yy)*