Andrus & Associates Dermatology, P.A.
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3809 Computer Drive, Suite 200 Raleigh, NC 27609 / Telephone: (919) 782-3782 / Fax: (919) 782-3788

Patient Information (Please Print) **Account Number:**

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

Address:_____ **Date of Birth:** ____/____/_____ **SSN:**_____-_____-_____

City: _____ **State:**_____ **Zip Code:** _____ **Email:** _____

Telephone Numbers: Home:_____ **Mobile:** _____ **Work:** _____
☐ Preferred ☐ Preferred ☐ Preferred

We attempt to contact the "Home" number for appointment reminders. If you would prefer us to contact you at another number, please check the box below the appropriate number. We will leave a message on the voicemail/answering machine if you are unavailable.

Other Information

Primary Care Provider: _____ **Phone:** _____ **Fax:** _____

Practice Name & Address:_____

Referring Provider:_____ **Phone:** _____ **Fax:**_____
*If different from above
Practice Name & Address:_____

In case of emergency, notify Name:_____ **Phone:** _____

Insurance Information

Primary Insurance Plan Name: _____ **Issuing Employer:**_____

Policy Holder's Name:_____ **Policy Holder's Date of Birth** ____/____/_____

Patient's Relationship to Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Secondary Insurance Plan Name: _____ **Issuing Employer:**_____

Policy Holder's Name:_____ **Policy Holder's Date of Birth** ____/____/_____

Patient's Relationship to Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Medical Information

DRUG ALLERGIES ☐ YES ☐ NO Please List:

Current Medication List: _____

_____

PLEASE INFORM THE DOCTOR IF YOU ARE PREGNANT OR NURSING.

Please check all of the following that apply:

☐**Cancer—Type/Location:**_____ ☐**High Blood Pressure** ☐ **Liver disease** ☐**Diabetes**

☐**Heart Disease** ☐ **Heart Surgery** ☐**Heart Valve Replacement** ☐**Pacemaker** ☐**Tuberculosis/Positive TB Test**

☐**HIV/AIDS** ☐**Hepatitis B** ☐**Hepatitis C** ☐**Glaucoma** ☐**Joint Replacement—Location:**_____

Other Health Problems & Surgeries:_____

Reason for Visit: _____/_____/_____

ASSIGNMENT OF BENEFITS

WE ARE REQIURED BY LAW TO HAVE YOUR SIGNED CONSENT TO FILE YOUR INSURANCE

COMMERCIAL INURANCE PLAN PATIENTS

I agree to allow Andrus & Associates Dermatology, P.A. to file my insurance on my behalf. I understand that I am responsible for paying any balance not paid by my insurance including my copay, annual deductible, coinsurance, non-covered, and cosmetic charges. I can find further details about Andrus & Associates Dermatology's Financial Policy on their website and by asking the receptionist for a copy. There is also a copy posted in the waiting room.

Patients covered by private commercial insurance plans which our providers are not contracted with are required to pay at the time of service. We will provide 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/Patient Representative: _____ Date:_____

TRADITIONAL MEDICARE PATIENTS

We are a participating provider with the standard Medicare Program, accepting assignment on all claims. Any coinsurance or deductible associated with your plan is due at the time of service. For any services not traditionally covered by Medicare you will be asked to sign an Advance Beneficiary Notice (ABN). The ABN will explain the service; ask if you want us to file it with Medicare, and explains that you understand the balance will be your responsibility should it not be covered by Medicare.

Our office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and acknowledge your agreement by providing your signature.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Andrus & Associates Dermatology, P.A.'s providers for any services furnished to me by that provider. I authorize release to Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

Signature of Patient/Patient Representative: _____ Date:_____

If you have a supplemental Medicare insurance policy, also known as a MediGap plan, Medicare will generally cross the claims over automatically. We are required to keep a signature on file for these plans authorizing us to file on your behalf.

I request authorized Medicare supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my Medicare supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient/Patient Representative: _____ Date:_____

MEDICARE ADVANTAGE PLAN PATIENTS

Medicare Advantage plans take the place of traditional Medicare. These plans usually have a copayment which is due at the time of service. There is more information on the Medicare Advantage plans we accept in our Financial Policy which can be found online, posted in the waiting room, and at the reception desk.

I authorize Andrus & Associates Dermatology, P.A. to file my Medicare Advantage plan on my behalf. I also authorize them to release any medical information needed to my plan to help determine benefits payable for related services.

Signature of Patient/Patient Representative:_____ Date:_____