

Towne Centre

FOR DERMATOLOGY

1750 Tree Boulevard, Suite 1
 St. Augustine, FL 32084
 (904) 824-4005 • Fax (904) 824-4009

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PATIENT INFORMATION				
Patient Name		Today's Date		Date of Birth
Parent if Patient Is a Minor		Marital Status		
Patient's Social Security Number		Driver's License No.		
Home Address		Mailing Address if Different		
City	State	ZIP	City	State ZIP
Home Telephone		Work Telephone		
Occupation		Employer's Name		
Employer's Address		City State ZIP		
Spouse Name		Employer		
Name of Primary Care Physician				
WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address		Home Telephone		
City	State	ZIP	Work Telephone	
Nearest Relative (not living with you)				
Home Telephone		Work Telephone		
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name		Telephone		
Address		City State ZIP		
Insurance Company		Claim Address		
Subscriber's Name		Subscriber's Date of Birth		
Subscriber's Social Security No.		Insurance ID No.		Group No.
Secondary Insurance		Claim Address		
Subscriber's Name		Subscriber's Date of Birth		
Subscriber's Social Security No.		Insurance ID No.		Group No.

(Please read our Financial Policy Statement and Agreement on reverse side.)

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OFFICE FINANCIAL POLICY

BASIC POLICY Pay for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurances for you. All copayments or deductibles are due and payable at the time service is provided.

MEDICAID PATIENTS Medicaid is only accepted as a secondary to medicare.

SURGERY FEES All copays, deductibles, and payments for noncovered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You will be charged a \$25 fee for missed appointments without 24 hours' notice and may be dismissed from the practice.

PAYMENT PLAN If you are having financial difficulty, please contact our billing personnel for possible alternative payment options.

FEE SCHEDULE All fees are based on usual and customary fees which have been determined by an independent research organization. If your insurance carrier's reimbursement is lower than the usual and customary fee, you may be held responsible for the difference.

Please check one: I have paid my insurance deductible for the calendar year_____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
<p>MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Taliaferro for any service furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.</p> <p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.</p>	
PROVIDER	
Patient's Name (Please Print)	
Patient's Signature	
Patient's Medicare No.	Date
<p>ASSIGNMENT OF INSURANCE BENEFITS Patients with insurances please read and sign below.</p> <p>I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Taliaferro. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.</p>	
Signature_____ Date_____	
I have read, understood, and agreed to the above financial policy for payment of professional fees.	
The patient is ultimately responsible for all professional fees.	
Signature_____ Date_____	