Dermatology, Laser & Vein Specialists
OF THE CAROLINAS

Midtown Medical Plaza ● 1918 Randolph Rd, Suite 550 ● Charlotte, NC 28207 ● 704-375-6766 ● 704-332-6552/Fax
1663 Campus Park Drive ● Suite A ● Monroe, NC 28112 ● 704-973-3650 ● 704-776-9998/Fax

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Apt #: _____

City: _____ State: ____ Zip Code: _____ Home Phone: ( ) _____ -_____

Cell: ( ) _____ - _____ Date of Birth: ____/____/_____ Age: _____

Sex: ____ Email: _____ Marital Status: _____

Ethnicity/Race: _____ □ Check here if decline to provide Primary Language:_____ □ Check here if decline to provide

Employer: _____ Occupation: _____ Work Phone: ( ) _____ - _____

Employer's Address: _____ City: _____ State: ____ Zip Code: _____

Spouse Name: _____ Occupation: _____ Work Phone: ( ) _____- _____

Reason for today's visit: _____

Referring Physician: _____ Address: _____ Phone: ( ) _____ - _____

Primary Physician: _____ Address: _____ Phone: ( ) _____ - _____

HEALTH INSURANCE INFORMATION □ Check here if same as above patient

Insured Name: _____ Date of Birth: ___/___/_____ SSN#: _____ (last 4 digits only)

Insurance Company: _____ Policy#: _____

Employer: _____ Address: _____

Employer Phone: ( ) ____ - _____ Patient Relationship to Insured: □ Spouse □ Child □ Other

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EMERGENCY CONTACTS

Person **living** with you:
Name: _____ Relationship: _____ Phone: ( ) _____ - _____
Person **not living** with you:
Name: _____ Relationship: _____ Phone: ( ) _____-_____

FINANCIAL RESPONSIBILITY: *I have read and understood the financial policy printed on the back of this registration* and agree that I am ultimately responsible for the balance of my account for any professional services rendered regardless of insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dermatology, Laser & Vein Specialists of the Carolinas, PLLC to release any information acquired in the course of my examination or treatment to the insurance carriers involved in the payment of my account. I authorize fax transmittal as needed.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dermatology, Laser & Vein Specialists of the Carolinas, PLLC.

DLVS reserves the right to refuse any service to any patient.

SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

Payment in full is expected at the time of your visit, unless prior arrangements have been made with our office. Your payment may be made to **'Dermatology, Laser & Vein Specialists of the Carolinas'** by cash, personal check or major credit card. If we have a contract with your insurance company and your insurance approves your visit, you will be responsible for the co-pay, deductible and co-insurance on the date of your service. We request that you are prepared for this at each visit and do not asked to be billed. Patients asking to be billed repeatedly will be directed to a supervisor and/or practice manager.

We file all medical and surgical care performed at **'Dermatology, Laser & Vein Specialists of the Carolinas'** to your insurance company. It is necessary that you provide us with accurate insurance information, a signed assignment of benefits and authorization to release information to your carrier(s).

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers and renewal dates are constantly changing. In order for us to file your claims to the appropriate plan, we must have the most recent card presented. **If you arrive without your card** you will be responsible for all charges until the billing office has received complete current and accurate insurance information. Most plans require that we file your claim within 90 days from the date of services. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we received payment from the insurance plan. Any balance you owe should be paid within thirty days.

Our filing of the insurance claim does not relieve the patient of his/her financial liability for the account. Most insurance companies do not pay 100% of a claim. Forty-five days should be allowed for payment of a claim by the insurance company after it has been filed. We do not normally know the amount that is disallowed by your insurance company or the reasons a claim has not been paid, therefore, PLEASE CONTACT YOUR INSURANCE COMPANY IF YOU HAVE QUESTIONS REGARDING THE CLAIM.

In the event that your insurance carrier refuses to make payments against your claim for services rendered by **Dermatology, Laser & Vein Specialists of the Carolinas**, for any reason, you agree to accept responsibility for prompt payment.

In the event of overpayment, a refund will be promptly made to the person responsible for the payment of the bill.

Patients who do not carry insurance or patients being seen by **Dermatology, Laser & Vein Specialists of the Carolinas** for a **cosmetic procedure are expected to pay in full at the time services are rendered. A deposit may also be required for specific cosmetic procedures at time of scheduling.**

RETURNED CHECKS: A service charge of **$25.00** will be charged to your account for any returned checks. You will be required to pay cash to cover the amount of the check plus the service charge.

MISSED APPOINTMENTS AND CANCELLATIONS: A **48-hour notice is required for all cancellations**. All appointments that are cancelled with less than 48 hour notice and all no showed appointments will be charged a **$25.00 fee**. All procedures cancelled with less than 48 hour notice and all no showed procedures will be charged a **$50.00 fee. Please note that after 2 no showed appointments or 2 appointments cancelled with less than a 48 hour notice the patient will have to speak with an Administrator before being able to reschedule.**

Thank you for taking the time to read and understand our policies. Please let us know if you have any questions.

PLEASE SIGN THE FRONT OF THIS FORM AS CONFIRMATION THAT YOU HAVE READ AND WILL ABIDE BY THE ABOVE POLICIES AND RESPONSIBILITIES.