PATIENT INFORMATION

NAME		☐ MALE	☐ FEMALE
ADDRESS	DATE OF BIRTH / /		AGE
CITY	STATE	ZIP CODE	E-MAIL ADDRESS
HOME PHONE ( ) CELL PHONE ( )	SOCIAL SECURITY # - -		☐ S ☐ M ☐ W ☐ D ☐ SEP.
OCCUPATION	EMPLOYER'S NAME		
WORK PHONE ( )	STUDENT? ☐ F/T ☐ P/T	SCHOOL NAME	
IN AN EMERGENCY PLEASE CONTACT: NAME	PHONE ( )		RELATIONSHIP

REFERRED TO PRACTICE BY:

DOCTOR	PATIENT	OTHER

INSURANCE INFORMATION

INSURANCE COMPANY NAME	PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NUMBERS	I.D. #	GROUP #	I.D. #	GROUP #
POLICY HOLDERS NAME				
POLICY HOLDER'S DATA	DATE OF BIRTH / /	☐ M ☐ F	DATE OF BIRTH / /	☐ M ☐ F
	ADDRESS			
	EMPLOYER'S NAME			

PERSON RESPONSIBLE FOR PAYMENT - If Different From Above

NAME	ADDRESS		
CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

* I authorize and assign payment from my insurance carrier directly to Barbara K. Honig, M.D., P.A. and Associates for covered services. I am financially responsible to Barbara K. Honig, M.D., P.A. and Associates for charges not covered by my insurance as well as costs of collection and reasonable attorney fees and any amount owed by me in the event Barbara K. Honig, M.D., P.A. and Associates refers my account to collections.

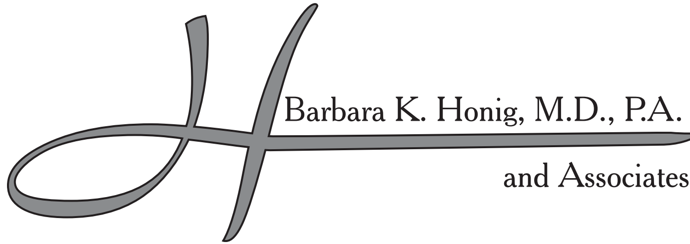
* I authorize Barbara K. Honig, M.D., P.A. & Associates to disclose my protected Health information for the purposes of treatment, payment and office management. A "Notice of Privacy Practices" (HIPAA) which provides more detailed information is available. PLEASE READ IT!

* I give permission to leave lab results and visit reminders on my:

answering machine ☐ voice mail ☐ e-mail ☐

DATE

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT, OR LEGAL GUARDIAN



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OFFICE AND FINANCIAL POLICIES

This letter has been prepared to help clarify frequently asked questions regarding fees, billing, and insurance coverage. Please be advised that we cannot bill insurance unless you provide us with a copy of your current insurance card. Please note that insurance coverage is a contract BETWEEN YOU and YOUR INSURANCE COMPANY—NOT between the doctor and your insurance company. The insurance companies are increasingly reminding us that they have NO obligation to pay the provider of the service, i.e. the doctor. Ultimately, you are responsible for the payment of any services rendered. In addition, most insurance companies have a deductible or co-pay/co-insurance which YOU are responsible for. Please consult the office staff before treatment is rendered if you have any questions.

FEES: The office visit fee covers the examination, discussion, and writing of prescriptions, or samples, for your skin condition. Some skin diseases or conditions may require more extensive evaluation or discussion. In these circumstances, the fee may be higher than the "standard" office visit. Surgical fees cover the surgical procedure. With certain procedures, there may be an additional charge for surgical supplies. Additional fees may be assessed for diagnostic tests, such as tissue examination for diagnosis of bacterial and fungal infections, pathological diagnosis of specimens, blood drawing, and photography.

PAYMENT:

- Our office participates with many health insurance plans.
- If we **DO** participate with your insurance plan, you will still be responsible for any deductibles, co-pay/co-insurance, or non-covered (cosmetic, medically unnecessary) portion of your bill. Payment is due at the time of service.
- If we **DO NOT** participate with your insurance plan, all fees will be collected at the time of service. A paid in full receipt will be given so you can file with your insurance company.

****MINOR PATIENTS:** Patients under the age of 18 must be accompanied by a parent or guardian at the time of service. Please understand that it is simply impossible for us to get in the middle of a family's struggle over who is responsible for the doctor's fees. All fees, co-pays/co-insurance are due at the time of service in concurrence with office policy.

CANCELLATION AND MISSED APPOINTMENT POLICY: If, for any reason, you cannot keep your scheduled appointment, please call 410-580-2880 with at least 24 hours notice. We reserve the right to charge for missed appointments or appointments cancelled with less than 24 hours notice. If a patient misses (no shows) 3 appointments, you may be notified and advised to find another practice to serve your dermatological needs.

MEDICAL RECORD COPYING POLICY: If medical records are requested by you, any of your other physicians, or an insurance company, you will be billed at the following rate in accordance with the Maryland State Law: A health care provider may require an authorizing person, who requests a copy of a medical record, to pay the cost of copying. A preparation fee of $21.00 and .69 cents per page as well as postage will be required payment for medical record retrieval and preparation/delivery.

There may be occasional changes due to holidays or other unforeseen events.
For all prescription refills, routine appointments, and non-urgent questions, please call during office hours.
Please arrive on time for all your appointments, and 15-20 minutes early for a procedure.
If you have an urgent problem during non-office hours, please call the office and follow the instructions on the recorded message.

We are dedicated to serving you promptly and courteously. Thank you.

PATIENT SIGNATURE: ______________________________________ DATE: ____