OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees or financial policy.

*All new patients will be asked to complete a "Patient Information Form" prior to being seen by the physician. We ask that you complete all information. We will request to make a copy of your insurance ID card and a form of pictured identification to remain a permanent part of your medical chart.

Unaccompanied Minors:

*The parents (or Guardians) of unaccompanied minors must provide written permission to treat the minor before the minor will be seen by the physician.

Insurance Information:

*If you are covered by Medicare, Champus or any managed care plan, we will file your insurance claim. **You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit.** Co-pays for office visits only cover the visit with the doctor. If there are any surgical procedures performed they may be subject to an additional co-pay, deductible, or co-insurance percentage. Please refer to your insurance policy contract for additional information.

*All self-pay patients are expected to pay for services in full at the time that services are rendered.

*In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember, that ultimately, payment responsibility rests with the patient. You should not rely on your physician's staff to know the details of your benefit plan. We work with many different health plans and are not familiar with the details of each plan. Be sure you are familiar with covered and non-covered services.

*Please advise the office personnel of any changes in your insurance, mailing address, phone number, name change or marital status.

*Should it ever become necessary to use the services of a collection agency to collect your account balance due, you will be responsible for any costs incurred for that purpose.

Please sign below to acknowledge your understanding of the above policy.

____

Responsible Party Date

Joy R. Boyne, M.D.,P.A.
Dermatology Center

Patient Information: (please print clearly)

Last Name:______________________________
FirstName:____________________MI________
Birth Date: ____/____/____ Age________
SS#:______-______-______ Sex: M F
Marital Status: S M D W
Address:______________________________
State& Zip:______________________________
Home Phone: ______-______-______
Cell Phone: ______-______-______
Work Phone: ______-______-______
Email:____________________@____________
Preferred method of contact:____________________

In the event we reach your voice mail, may we leave information including but not limited to office visit, confirmation of upcoming visit? ________________

Employer:______________________________
Occupation:______________________________

Guardian Information: (please print clearly)

Last Name:______________________________
FirstName:____________________MI________
Birth Date: ____/____/____ Age________
SS#:______-______-______ Sex: M F
Marital Status: S M D W
Address:______________________________
State& Zip:______________________________
Home Phone: ______-______-______
Cell Phone: ______-______-______
Work Phone: ______-______-______
Email:____________________@____________
Preferred method of contact:____________________

In the event we reach your voice mail, may we leave information including but not limited to office visit, confirmation of upcoming visit? ________________

Employer:______________________________
Occupation:______________________________

Insurance Information:

(this must be filled out if we are providers for your insurance)

Primary Ins:______________________________

Policy Holder Name:________________________

Insured's SS#:_______-_______-_______

Relationship to insured:____________________
Birthdate:_______/_______/_______

Employer:______________________________
Work Phone: ______-______-______
Ins. ID#: ______________________________
Group #: ______________________________

Ins. Co. Address:__________________________

City,State & Zip:__________________________

Secondary Ins:______________________________

Policy Holder Name:________________________

Insured's SS#: _______-_______-_______

Relationship to insured:____________________
Birthdate: _______/_______/_______

Employer: ______________________________
Work Phone: ______-______-______
Ins. ID #:______________________________
Group #: ______________________________

Ins. Co. Address:__________________________

City,State & Zip:__________________________

Primary Physician's full name:________________________ Office Phone #______-______-______
In case of emergency we may contact: ______________________________
Address: ______________________________
City,State & Zip: ______________________________
Home Phone: ______-______-______Cell Phone: ______-______-______Work Phone:______-______-______
How did you hear about Dr. Joy Boyne?______________________________
____
(If a doctor referred you please give full name, address and Phone #)

I authorize the release of any medical information necessary to process this claim. (if applicable, I also request payment of government benefits to the party who accepts this assignment.)

Patient or Guardian Signature:______________________________Date_____/______/________

Joy R. Boyne, M.D.,P.A.
Dermatology Center

Medical History Information

Have you ever been seen by a dermatologist before? Yes No (for what and when?) ______________________________
____

My general health is: (circle one) Excellent Good Fair Poor

Do you smoke? Yes No How many per day?_________________ Number of alcoholic drinks per week_____________

List allergies (include medications and food)____

List all current medications (list over the counter and prescription including supplements)____________________________
____

List any previous surgeries, hospitalizations, and serious injuries in the past year ___________________________________
____

Have you ever had any light, phototherapy, or x-rays for a skin condition? Yes No When?___________________________

FOR WOMEN ONLY: Are you pregnant? Yes No (if yes how many weeks__________________)
Are you nursing? Yes No

Family History: (who?) Asthma/allergies/hay-fever______________________Diabetes______________________________
Skin cancer______________________Melanoma_____________________________

Recent foreign travel: (where and when?)____

Please circle YES or NO to the symptoms or diseases that **you have or have had in the past:**

Stroke YES NO
Fainting or Blackouts YES NO
Epilepsy or Seizures YES NO
Glaucoma or Cataracts YES NO
Thyroid Disease YES NO
Diabetes YES NO
Asthma/Hay-fever/Hives YES NO
Tuberculosis/lung disease YES NO
Shortness of breath YES NO
Chest Pain/angina/heart attack YES NO
Ulcers or Colitis YES NO
Hepatitis YES NO

Heart murmur or abnormal EKG YES NO
Irregular heartbeat or palpitations YES NO
Cardiac pacemaker or artificial heart valve YES NO
Kidney or Bladder problems YES NO
Anemia (low blood count) YES NO
Excessive bleeding when cut or bruising YES NO
Poor healing of wounds or cuts YES NO
Abnormal scarring (keloids) YES NO
Blood or plasma transfusion YES NO
Hi or Low Blood pressure YES NO
Liver or Gallbladder disease YES NO

Cancer YES NO (type and treatment)____
Sexually transmitted disease YES NO (type and treatment)____
Melanoma YES NO (type and treatment)____
Problems with local anesthetics YES NO (type and reaction)____

List any other medical problems not listed____
____

____
Print name Signature Date

PATIENT ACKNOWLEDGMENT TO RECEIVE PAPER COPY OF NOTICE OF PRIVACY PRACTICES

I ____________________________ understand that under HIPAA Regulations, I have the
Print name

right to request and receive a paper copy of the Notice of Privacy Practices.

_____ I do not wish to receive a copy of the Notice of Privacy Practices Policy.

_____ I requested and received the Notice of Privacy Practices.

____

Patient Signature or Authorized Representative Date

Joy R. Boyne, M.D., P.A.

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Fax 904-281-0852