Raleigh Skin Surgery Center, pllc

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

3811 Ed Drive; Suite 110 • Raleigh, NC 27612 • Phone: (919) 390-0200 Fax: (919) 390-0219

Patient Registration Form *(Front & Back)*

Name: _____ **Title:** ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.
First Middle Last

Mailing / Billing Address: _____
Street # Street Name Apt #

_____
City State Zip Code

Date of Birth: _____ **Preferred Phone:** (_____) _____ ☐home ☐work ☐cell

Home Phone: (_____) _____ **Alternate Phone:** (_____) _____ ☐work ☐cell

☐ **Male** ☐ **Female** **Employer's Name:**_____ **If Student:** ☐Full Time ☐Part time

How did you hear about the Raleigh Skin Surgery Center? _____

Our financial policy: Payment is expected from you, at the time of service, for **"your part"** of the charges for services covered by insurance. Insurance coverage will be pre-verified and you will be responsible for any **unmet deductible, coinsurance, and/or copayments**. Cosmetic patients must pay in full at the time of service. We accept cash, personal checks, VISA and Mastercard. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Raleigh Skin Surgery Center, PLLC to release such medical information necessary to your primary care or referring physician, to consultants if needed, and to the insurance company(s) listed below in order to process your insurance claim (if any). You herein authorize payment of medical benefits to Raleigh Skin Surgery Center, PLLC when an assigned claim is filed to the following insurance company(s):

Primary Insurance

Primary Insurance Company: _____

Subscriber/Member ID#: _____ **Group #:** _____

If different than yourself: Name of policy holder: _____

Policy Holder's Date of Birth: _____/_____/_____

Your Relationship to policy owner: ☐ Spouse ☐Child ☐Other

Secondary Insurance

Secondary Insurance Company: _____

Subscriber/Member ID#: _____ **Group #:** _____

If different than yourself: Name of policy holder: _____

Policy Holder's Date of Birth: _____/_____/_____

Your Relationship to policy owner: ☐ Spouse ☐Child ☐Other

****Please be sure to sign below in order to allow us to file your claim to the insurance(s) listed above.****

_____ _____
Signature of Patient or Personal Representative Date

Patient Label

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HIPAA Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge this office's Notice of Privacy Practices, which explains how medical information about me may be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

Patient Label