Steven Rotter, M.D.
Center for Skin Surgery
Skin Cancer Outpatient Surgical Hospital

Welcome to Our Office

Name:_____**Today'sDate:**_____/_____/_____
Last First Middle
Address:_____
City:_____ **State:**_____**Zip Code:**_____
Telephone:(**)**_____**Birthdate:**_____/_____/_____ **Age:**_____ **M**___**F**___
Cell Phone : (**)** _____ **Work : (** **)** _____
Social Security Number:_____-_____-_____ **Occupation:**_____
Employer:_____

Primary Insurance

Name of Company:_____

Address to Send Claim:_____

Policy #:_____ **Group #:**_____

Insured's Name:_____**D.O.B.**____/____/____ **Relationship to Patient:**_____

Insured's Social Security Number:_____-_____-_____ **Insured's Employer:**_____

Secondary Insurance

Name of Company:_____

Address to Send Claim:_____

Policy #:_____**Group #:**_____

Insured's Name:_____**D.O.B.** ____/____/____**Relationship to Patient:**_____

Insured's Social Security Number:_____-_____-_____**Insured's Employer:**_____

Financial

- **Cosmetic procedures are always payable on the day of service.**
- **All copays and DEDUCTIBLES are due at the time of service. It is illegal to waive these fees.**
- **If we participate with your insurance company, we will file the claims for you.**
- **If your insurance requires a referral, IT IS <u>YOUR</u> RESPONSIBILITY to have a valid referral in this office EACH time you are seen.**

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of insurance benefits. I authorize the release of any medical or other information necessary to process my claim(s). I also accept responsibility for any legal fees and collection agency charges which may be occured if I fail to pay all balances due within 90 days of service. I permit a copy of this authorization to be used in place of the original.

Signed:_____ **Date:**_____/_____/_____
(Patient or Parent if Minor)
In case of an emergency, contact:_____**Relationship:**_____
Home phone #:(**)**_____ **Work Phone #:(** **)**_____
Referred By:_____

<u>PRIVACY NOTICE</u>
I have received a copy of the Notice of Privacy Practices for the above named practice.

Signed: _____ **Date** _____/_____/_____