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**PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender: M ( ) F ( ) Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Guarantor's Name (if patient is a minor) \_\_\_\_\_ Relationship: \_\_\_\_\_

*WHOM MAY WE THANK FOR REFERRING YOU?* \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

**INSURANCE INFORMATION: This information is required**

**Primary Insurance Information**

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: M( ) F ( )

Insured's Address (if different from patient's): \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_ Group Policy Number: \_\_\_\_\_

**(FOR OFFICE USE ONLY) Benefit Verification**

Date \_\_\_\_\_ Initials \_\_\_\_\_ Person Spoke With \_\_\_\_\_  In Network or  Out of Network

**Secondary Insurance Coverage:**

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: M( ) F ( )

Insured's Address (if different from patient's): \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_ Group Policy Number: \_\_\_\_\_

**(FOR OFFICE USE ONLY) Benefit Verification**

Date \_\_\_\_\_ Initials \_\_\_\_\_ Person Spoke With \_\_\_\_\_  In Network or  Out of Network

**Tricare/Tricare for Life:**

Sponsor's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Status: \_\_\_\_\_

# **DERMATOLOGY SURGERY CENTER**

## **ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby authorizes the release or any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Scott L. Beals, D.O.. I authorize the release of any medical records for treatment, payment or healthcare operations.

**INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE.**

## **RELEASE OF PATIENT INFORMATION**

I acknowledge that records concerning the patient are the property of Dermatology Surgery Center and are maintained for the use and benefit of Dermatology Surgery Center and its staff in providing care and treatment to the patient. I hereby authorize Dermatology Surgery Center to disclose all or any part of my patient records to my admitting physician, consulting physician(s), hospital based physicians. I further authorize Dermatology Surgery Center and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Dermatology Surgery Center or to me or a family member of mine, for all part of Dermatology Surgery Center's charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations..

## **FINANCIAL AGREEMENT**

For and in consideration of services rendered, each of the undersigned agrees to pay Dermatology Surgery Center for all charges not covered by insurance as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by Dermatology Surgery Center including reasonable attorney's fees which shall include but not be limited to such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statutes 222.111, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of the family which are greater than \$500 per week garnished.

**PLEASE NOTE: PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF \$50.00.**  
**Cosmetic procedures must be paid two days prior to the procedure to avoid a \$50.00 charge.**

## **ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES (HIPPA Privacy Guidelines)**

The Dermatology Surgery Center Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted. By signing this form, I acknowledge that I have been offered and/or received the Dermatology Surgery Center Notice of Health Information Practices.

## **AUTHORIZATION FOR MEDICARE CARE AND TREATMENT**

1. I recognize that a condition exists requiring medical care and I voluntarily consent to such medical care and treatment, diagnostic procedures by Dermatology Surgery Center and its medical and professional staffs, associates and agents and as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray diagnosis or therapy as he considers necessary and proper in the treatment of the patient.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Dermatology Surgery Center.

The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date