

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: (_____) _____ Type: Home | Cell | Work

Secondary Phone Number: (_____) _____ Type: Home | Cell | Work

SSN: _____ Email Address: _____

How would you like to receive your appointment reminders? By Text or Phone Gender: Male or Female

Preferred Language: English or other: _____ Marital Status: Married Divorced Widowed Single

Race: White/ Caucasian Native American/ Alaskan Native African American Asian

Native Hawaiian/ Pacific Islander or Other _____

Emergency Contact Name: _____ Relationship: _____

Primary Phone Number: (_____) _____

please list a number different than yours

Secondary Phone Number: (_____) _____

Patients Employer Name: _____

Patients Employer Phone Number: (_____) _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form & Nondiscrimination statement

Dr. Susannah L. Collier M.D.

I am a patient of Dr. Susannah L. Collier M.D.; I hereby acknowledge receipt of Dr. Susannah L. Collier's Notice of Privacy Practices & nondiscrimination statement. Dr. Susannah L. Collier M.D. PLLC's waiting area and upon request we will give you a copy of our Notice of Privacy Practices

Name: _____ or Guardian/ POA Name: _____

Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Dr. Susannah L. Collier M.D.

With my consent, Susannah L. Collier M.D., PLLC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and Healthcare Operations (TPO). Please refer to Dr. Susannah L. Collier M.D. PLLC's waiting area and upon request we will give you a copy of our Notice of Privacy Practices. Dr. Susannah L. Collier M.D. PLLC representative of her or an authorized office has permission to discuss my medical conditions, information, test results, and or laboratory findings with the these

non-medical individuals (i.e. spouse, children, sibling, family member, friend, etc...):

Name & Phone: _____

Name & Phone: _____

Name & Phone: _____

Patient Signature: _____ Date: _____

Assignment of Benefit Statement, Financial Options for Payment Arrangements and Financial Agreement

You acknowledge that your insurance is your responsibility

As a courtesy, we will be happy to file an insurance claim on your behalf. However there are several administrative steps that are required prior to your surgery and/or appointment:

*if your insurance requires a written referral or authorization, it is your responsibility to obtain it

* If you have a biopsy or excision done (NOT Mohs), it will be sent to a pathologist for diagnosis (usually Clay Cockerell, MD) unless you notify our office that you need it to be sent to a specific lab. This is a separate charge and any billing questions regarding the pathology need to be addressed with the pathologist's Office.

*Our office may not be contracted with all insurance companies; if this is the case, your 'out of network' benefits, if you have them, will apply.

*After the insurance claim is processed, we will bill you for the balance on your account and this balance is due immediately.

* If your insurance company does not pay your claim within 90 days of the date of service you will be responsible for the full balance.

*Co-pays, coinsurance, and/or deductibles will be your responsibility whether in or out of your insurance network.

You acknowledge that Dr. Susannah L. Collier M.D. requires payment at the time of service.

This could be your copayment and/or a portion of your deductible and/or coinsurance be collected at the time of any appointment if you are insured. Any balance your insurance puts to your responsibility is due immediately following your first statement. If you are self-pay, the total is due at the time of your appointment.

You acknowledge that Dr. Susannah L. Collier M.D. Charges \$35.00 for returned checks.

You acknowledge you have the following payment options: Cash, Check, Visa, MasterCard, or Discover Card.

You acknowledge there is a 6 month Payment Plan Option after your insurance processes your claim.

I understand that Susannah L Collier, MD, on a needs based basis, offers a 6 month interest free payment plan if I am not able to pay by balance after my insurance has paid their portion. I understand that this six months starts the month of the first statement sent by Collier Skin Cancer Center (CSCC). I understand that it is my responsibility to call CSCC and speak with the billing department to qualify for this payment plan. I understand that my total balance is divided over 6 months and this amount (1/6 of total balance) is due each month whether I receive a statement from CSCC or not. I understand that I am welcome to make a month payment that is larger to the month payment amount but each month my payment of 1/6 of my total balance has to be received by the last day of the month to keep my account in good standing. I understand that a partial or missed payment will result in being sent to collections. Any account sent to collections regardless of whether a payment plan is in place or not will result in additional fees. I understand that by signing this I am not agreeing to a payment plan, and should I want to take advantage of this option I have to call CSCC once I receive my first statement.

I authorize payment directly to Dr. Susannah L. Collier M.D., PLLC from my insurance company

I hereby authorize payment directly to Dr. Susannah L. Collier M.D., PLLC, of all surgical and/ or medical benefits otherwise payable to me for services (but not in excess of Dr. Susannah L. Collier's charges). Any unpaid deductibles and / or co-pays not payable by my insurance company on the day of evaluation and/ or surgery I am responsible for. I understand that charges not payable by my insurance company (i.e. co-insurance, and/or deductible) are my responsibility and are due in full within 90 days from the date of service regardless of any insurance pending. I understand that I have options to assist me in paying for the services provided by Dr. Susannah L. Collier MD, if I am unable to pay the full balance. By signing this, you agree and understand the above terms and conditions.

I acknowledge that I have read and understand the above information.

Patients Name: _____ D.O.B. _____

Patients Signature: _____ Date: _____

Parent or guardian name (if patient is under 18) _____ Date: _____

Parent or guardian Signature: _____ Date: _____

Patient Name: _____ Date: _____

Yes No Tobacco use (vapes, cigs, chew)? If yes, How much? _____

Yes No Former tobacco user?

_____ (#) Alcohol Use: how many times in the last year have you consumed 5+ drinks (4+ if female) in one setting.

Yes No New or Changing Moles?

Yes No Immune Suppression (cancer/ medication caused/ transplant)?

Yes No Artificial Joints or Heart Valves? _____

Yes No Allergy to adhesive or lidocaine or Betadine?

Yes No Any medication allergies? If yes, which ones? _____

Yes No Anxiety?

Yes No Diabetes?

Yes No Females: Are you Pregnant?

Yes No Aged 65 years+: Do you suffer from urinary incontinence?

Yes No Psoriasis?

Yes No History of Staph infection/ MRSA?

Yes No High Blood Pressure?

Yes No Any other Cancer? _____

Yes No Does your insurance require a specific pathology lab? (Clay Cockerell, MD is who we use)

Yes No Prefer Not to Answer: Do you have a Living Will/ Advanced Directive?

Yes No Prefer Not to Answer: Do you have someone who will make medical decisions for you
if you become demented or incapacitated?

Anything else we should know about you, medically? _____

Referred by: _____

Primary Care Physician: _____

Pharmacy (name, city and intersection): _____

PLEASE LIST ALL MEDICATIONS with Dosages & when taken: (OR provide a list)

_____	_____	_____
_____	_____	_____
_____	_____	_____