# Skin & Laser Surgery Center, P.C.

## Mohs Surgery, Cosmetic Skin Surgery, Laser Skin Surgery

**Amir Bajoghli MD, Seema Doshi MD, Sylvia Parra MD, Janice Rasmussen, NP-C**

8130 Boone Blvd , Suite 340, Tysons Corner , Virginia 22182 2200 Opitz Blvd, Suite 245, Woodbridge, Virginia 22191


## PATIENT INFORMATION

Date: (month) _____ /(day)______/(year)__________

**Name**: ______________________________________________
(Last) (First) (MI)

***PATIENT*** *would like to be called? (nickname, ect...)*:______________________

Address: ______________________________________________
(Street Address) (Town/City) (State) (Zip)

Home Telephone No: ______________________ Cell Phone No: ______________________

Social Security #: ______________________ Email: ______________________

Date of Birth: ____/_____/_____ Age: _________ Sex: Male ___ Female ___ Marital Status: ____Single____ Married____ Other

Is patient employed? : YES NO (Please Circle) If employed, please fill out the following:
Name of Employer: ______________________
Employer Phone No:______________________Employer Address: ______________________

## ADDITIONAL INFORMATION

1. Name of PRIMARY CARE PHYSICIAN: ______________________

Phone: ______________________ Address: ______________________

2. Please list the names of any other physicians whom you see: ______________________

______________________________________________

3. How did you hear about us? PLEASE Circle ALL that applies:
   a. Insurance Company Website or Directory
   b. Friend/ Relative/Colleague______________________
   c. Doctor's Name: ______________________
   d. Yellow Pages (Verizon / Yellow Book/ Local-Community Book) e. Google Search
   f. Internet/Website name: ______________________
   g. Other ______________________

4. Name of parents or guardian (if patient is child):
Father: ______________________ SS#: ______________________
Mother: ______________________ SS#: ______________________

5. Emergency Contact :
Name: ______________________
Relation to patient:: ______________________
Phone number: ______________________

6. **TEST RESULTS:**
What is the best way for us to notify you with any TEST RESULTS? Phone (_____)______________________

May we leave a message? **YES/NO** with Spouse, Household member, Other______________________

***PLEASE TURN OVER.***

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## PRIMARY Insurance Information

**Name of Policy Holder:** ______________________________________________

**Date of Birth of Policy Holder:** _____/______/_______ **Social Security No. of Policy Holder:** _____-_______-________

**Name of Primary Insurance:** ________________________ **ID NO:** ___________________________________
**Primary Insurance Co. Phone No:** _________________________

**Address:** ______________________________________________________________________
(Street/P.O. Box) (Town/City) (State) (Zip Code)
**Employer Insurance Plan?** ___________ **Yes** ___________ **No**
**Relationship of Patient and Policyholder:** _____**Self**_______ **Husband**_____ **Wife**_____ **Child** _____ **Parent**

## SECONDARY Insurance Information

**Name of Policy Holder :** _________________________________ **Date of Birth of Policy Holder:** _____/______/_______

**Social Security No. of Policy Holder:** _____-_______-________

**Name of Secondary Insurance:** _______________________ **ID NO:** ___________________________________
**Secondary Insurance Phone No:** ___________________________

**Address:** ______________________________________________________________________
(Street/P.O. Box) (Town/City) (State) (Zip Code)
**Employer Insurance Plan?** ___________ **Yes** ___________ **No**
**Relationship of Patient and Policyholder:** _____**Self**_______ **Husband**_____ **Wife**_____ **Child** _____ **Parent**

**Insured's Employment Information:**
Name of Employer: _________________________________________ Phone: ______________________________
Address: ________________________________________________________________________________

**ASSIGNMENT & RELEASE**

I hereby authorize Skin & Laser Surgery Center, PC to apply for benefits on my behalf for covered services rendered. I, further, authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. Either my insurance carrier or I may revoke this authorization at any time in writing. I certify that information I have reported with regard to my insurance coverage is correct. I authorize Dr. Bajoghli, Associates and staff to treat me. I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

I understand and agree that *I am financially responsible for charges not covered by my insurance* company.

**APPOINTMENT POLICY**

There will be a $50.00 charge for a NO SHOW office visit or an $85.00 charge for NO SHOW SURGERY appointment. We strictly enforce this policy, so please take time to carefully select your appointment time. A broken appointment is a cancellation without a 24-hour notice, lateness that results in the inability to properly complete the treatment planned, or not being present for the scheduled appointment. This charge is the patient's responsibility and is not reimbursed by the insurance company.

**PAYMENT POLICY**

Self pay accounts and co-pays are due at the time of service; there is no exception to this policy. If it becomes necessary to turn your account over to a collection agency/attorney, there will be a charge of 35% additional fee applied to your total balance to cover attorney's fees and other collection costs. If your check bounces (due to insufficient funds or any other reason) you will be charged $50.00.

I authorize Skin & Laser Surgery Center, PC to deduct my bounced check amount AND the associated fees (minimum of $50) from my bank account directly through Automated Clearing House (ACH) or credit card statement on file. A 1.5% monthly finance charge will be charged to all due past due amounts. We ask for a credit card number to stay on file. I authorize Skin & Laser Surgery Center, PC to collect the fees associated with patient responsibility of medical and surgical services rendered via my **credit cards** statement on file. This may include **co insurance amount, deductibles, co-pays, or any other balances due.**

**INSURANCE COVERAGE**

It is not Skin & Laser Surgery Center's responsibility to confirm whether the patient has in-network or out of network benefits. Ultimately, it is the patient's responsibility to confirm what their coverage benefits are with their insurance company.

**X**______________________________________________ ________________________________________
**SIGNATURE OF PATIENT, PARENT OR GUARDIAN** **DATE**

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________________________

Relationship to Patient: ______________________________________________

Signature: X______________________________________________

Date: ______________________________________________

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

**SKIN & LASER SURGERY CENTER, P.C.**
**AMIR A. BAJOGHLI, M.D.**

*Fellow, American Academy of Dermatology*
*Diplomate, American Board of Dermatology and Internal Medicine*
*MOHS Micrographic Surgery • Laser Cutaneous Surgery*

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit and will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask our billing department at billing@drbajoghli.com 703-492-4140 Ext. # 126

Sincerely yours,

Skin & Laser Surgery Center, P.C.

I authorize **Skin & Laser Surgery Center, P.C.** to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express Other: ______________________________

Account number __________________________________ Expiration Date _____________

Name on card (please print) ____________________________________________________

Signature __________________________________________ Date ______________________