Phone: (919) 363-7546 Fax: (919) 363-3616

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

CARY SKIN CENTER
Skin Cancer Center

Accredited by
Accreditation Association for Ambulatory Health Care, Inc.

Patient Registration Form *FORM C*

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

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

_____
City **State** **Zip Code**

Home Phone: (_____)_____ **Work Phone: (_____)_____** **Cell Phone (___)_____**

Date of Birth: ____ / _____ / _____ **Sex:__ M ___F** **Social Security #_____Student ___ Full Time __ Part Time**

_____
Employer Name **Address** **Phone**

Are you a resident of a Skilled Nursing Facility? ☐ **Yes** ☐ **No or Hospice?** ☐ **Yes** ☐ **No**

If married, Spouse: _____ **Spouse's Date of Birth:** _____ **/** _____ **/** _____
Month **Day** **Year**

How did you hear about Cary Skin Center? _____

FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. 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 PREVERIFIED 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, MASTERCARD, AMERICAN EXPRESS AND DISCOVER. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Cary Skin Center 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 Cary Skin Center when an assigned claim is filed to the following insurance company(s):

Primary Insurance: _____ **Secondary Insurance:** _____

Name of policy holder other than patient: _____

Social Security # of policy holder: _____ **Date of birth of policy holder:** _____/_____/_____

Patient relationship to policy owner: ☐ **Spouse** ☐ **Child** ☐ **Other**

- ✓ **Signature of Patient or Legal Guardian** _____ **Date**_____

IMPORTANT INFORMATION FOR NEW PATIENTS

Federal Law requires all healthcare practices to obtain, verify and record information that identifies each patient.

What this means for you: When you arrive at Cary Skin Center, PA, we will ask to see a photo ID issued by a local, state or federal government agency such as a driver's license, passport or military ID. If you do not have a government issued photo ID, please bring two forms of nonphoto ID such as Social Security Card, school or company ID or a utility bill with your name and address visible.

Please contact Cary Skin Center, PA prior to your appointment if you do not have available forms of identification. You may reach us at (919) 363-7546.