Kayal Dermatology & SKIN CANCER SPECIALISTS

Self-Pay or Insurance Information

Are you a self-pay patient not using insurance? YES ☐ or No ☐

Do you have a prescription drug plan? ? YES ☐ or No ☐

(Please complete this form if you are using insurance.)

1 _____

Primary Insurance Information

_____ _____

Member ID Number Group Number

_____

Claims Mailing Address City State Zip Code

_____ _____ _____

Policy Holder's Name Date of Birth Social Security #

2 _____

Secondary Insurance Information

_____ _____

Member ID Number Group Number

_____

Claims Mailing Address City State Zip Code

_____ _____ _____

Policy Holder's Name Date of Birth Social Security #

We are committed to meeting your health care needs. Our goal is to keep your insurance and financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. Payment for services including any deductibles, coinsurance and copayments will be collected at the time of service.
2. All outstanding patient balances beyond 90 days from the original date of service are subject to a referral to a collections agency.
3. A current copy of your insurance card must be presented at each visit. Any charges not paid by your insurance based on your failure to provide a current ID card will be upheld as the patient's responsibility.
4. Appointment cancellations in less than a 24 hour notice are subject to a $50 cancellation fee.
5. I have read and understand the Privacy Statement provided to me within HIPPA regulations and guidelines applicable to the (electronic) storage of my medical records.

I understand that my insurance benefits are subject to change. It is my responsibility to understand these benefits as they apply to all covered and non-covered services. I acknowledge that I understand and accept my financial responsibility as a patient.

Signature: _____ Date: _____