Hancock Dermatology

Patient Information

Full Legal Name: _____ DOB: _____

Address: _____

Home Phone: _____Cell Phone: _____ Best Contact: Home or Cell

Marital Status: _____ Sex: M or F Social Security Number: _____

Email Address: _____ Authorization to email: Y or N

Employer/School: _____ Phone: _____

Names of family members treated at Hancock Dermatology: _____

Have you seen Dr. Sanford previously: Y or N

Responsible Party Information

Primary Insurance Company Name: _____
Policy Number: _____ Group Number: _____
Policy Holder Name: _____ DOB:_____ Relationship: _____

Secondary Insurance Company Name: _____
Policy Number:_____ Group Number: _____
Policy Holder Name: _____ DOB:_____ Relationship: _____

Emergency Contact Information

Name: _____Phone: _____Relationship: _____

Physician Information

Primary Care Provider: _____ Phone: _____
Referring Provider: _____Phone:_____

Pharmacy Information

Local Pharmacy Name: _____Cross Streets: _____Phone: _____
Mail Order Pharmacy: _____ Phone Number: _____
Prescription Card ID: _____ Group: _____

400 W Green Meadows Drive #110
Greenfield, IN 46140
P: 317-967-7921
F: 317-967-7122
www.hancockdermatology.com

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Minor Children

In case of children whose responsible party is someone other than the custodial parent, we must ask that payment for copay's, ect. be made at the time of service by the person accompanying the child to the office.

Father/Legal Guardian
Name: _____ DOB:_____ SSN: _____
Address: _____ Phone: _____
Employer: _____ Employer Phone: _____

Mother/Legal Guardian
Name: _____ DOB:_____ SSN: _____
Address: _____ Phone: _____
Employer: _____ Employer Phone: _____

I give the following person permission to accompany my child to office visits and give them authority to make decisions about treatment.

Name: _____Phone: _____Spouse: _____

I authorize Hancock Dermatology to examine and treat my child.

Signature of Parent/Legal Guardian: _____ Date: _____
Printed Name of Parent/Legal Guardian: _____ Date: _____

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Release of Information

I give permission to Hancock Dermatology to release any information pertaining to my chart to the following person, this may include pathology, billing services, diagnoses, and treatment plans:

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

I hereby assign my insurance benefits to be paid directly to Hancock Dermatology. I am aware that I am financially responsible for ALL NON-COVERED services. I understand that it is my responsibility to know my insurance policy and what it requires pertaining to referrals, timely filing, and authorizations. I also authorize the physician to release my information required to process my claim to my employer or insurance company.

I understand that all charges are to be paid at the time of service unless I present a valid insurance card that represents insurance carriers with whom Hancock Dermatology has contractual agreements with. *All deductibles, copays, and non-covered services are expected to be paid at the time of service*. I also understand that if any insurance does not pay my claim within 60 days of billing, I am financially responsible. **All balances that go over 90 days are subject to placement with a collection agency. If my account is turned over to an outside collection agency, I agree to be responsible for all costs of collection including but no limited to interest charges at the current legal rate, reasonable attorney fees and court costs. Furthermore, I understand I may be dismissed from the practice.**

I am aware that Hancock Dermatology has a no-show policy and understand if I fail to keep 3 appointments without giving 24 hours' notice I am subject to be dismissed from the practice.

Signature of Patient/Responsible Party: _____ Date: _____
Printed Name of Patient/Responsible Party: _____ Date: _____

I acknowledge that I have been offered or received a copy of the Health Insurance Portability and Accountability Act (HIPAA Privacy Act) and am aware that Hancock Dermatology will not release my information unless outline above.

Signature of Patient/Responsible Party: _____ Date: _____

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