LAMONT W. HORNBECK, M.D.

CLINICAL DERMATOLOGY AND CUTANEOUS SURGERY

PATIENT REGISTRATION

Name _____
Last First MI

Address _____
Street City State Zip

Telephone ( ) _____ ( ) _____ ( ) _____
Home Cell Work

DOB _____ SSN _____ Marital Status ☐S ☐M ☐ D ☐ W

Email _____ Gender ☐ Male ☐ Female

Emergency Contact _____
Last Name First Name Relation Phone Number

INSURANCE INFORMATION

Please present all your insurance card to the receptionist

☐ **Self Pay (no insurance)**

Primary Insurance _____ Secondary Ins _____

Policy Holder _____ DOB _____

PARENT, GUARDIAN, OR RESPONSIBLE PARTY (*if different from patient*)

Name _____ Relation to patient _____

DOB _____ SSN _____ Contact Number _____ ☐Home ☐Cell

Address ☐Same as above Alt. Address _____
Street City State Zip

Is this visit related to an injury at work? ☐YES ☐NO Are you currently employed? ☐YES ☐NO
Do you have any other health coverage? ☐YES ☐NO Have you ever served in the military? ☐YES ☐NO

TELEPHONE COMMUNICATION RELEASE

May we leave medical information on your home answer machine? ☐ YES ☐ NO
May we leave medical information on your cell voicemail? ☐ YES ☐ NO
May we discuss your medical information with family members? ☐ YES ☐ NO
If yes, please list: _____
Phone

Authorizations

I request that payments of authorized benefits be made on my behalf to the provider for any services furnished to me.
I authorize my provider and staff to view and send my prescription to
I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.
I have received/or reviewed a copy of the Notice of Privacy Practices from Lamont W. Hornbeck MD, Inc.

Signature _____ **Date** _____
Patient/Responsible Party

729 Sunrise Avenue ▪ Suite 700 ▪ Roseville, CA 95661 ▪ 916.782.3721 ▪ Fax 916.782.0618

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FINANCIAL POLICY

As a service to you, we will bill your insurance carrier(s) provided to us. Please keep in mind that your insurance policy is basically a contract between you and your insurance company. However, you are ultimately responsible for the payment of services. If an insurance carrier has not paid within 60 days, you may be responsible for paying any outstanding balances. It is your responsibility to pay for any applicable deductibles, co-payments, co-insurance, or non-covered/cosmetic services on the day of the appointment.

- Payments are due at the time of service.
- Payment for private pay patients, cosmetic, or non-covered services are due at the time services are rendered.

There is a $25 charge for checks returned for insufficient funds. If past due bills are sent to collections, payments must be made directly to the collection agency.

PARTICIPATING PLANS

Insurance coverage is not a guarantor of payment. As your insurance is a contract between you and your insurance carrier, it is your responsibility to know your coverage eligibility, deductibles, copays, and network requirements. Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances. We cannot legally discount fees after their submission on your behalf to the carrier and writing off balances could jeopardize our contract with your carrier. We are legally obligated to collect the patient responsibility: co-insurances, co-payments, or deductibles under the term of the Anti-Kickback laws.

NON-PARTICIPATING PLANS:

Dr. Hornbeck is not contracted with any HMO or MediCal lines of business/insurances. It is against the law for Dr. Hornbeck to treat MediCal patients in exchange for direct payment. It is also against the law for MediCal patients not to inform the provider of their MediCal status. If you obtain MediCal insurance during your care, our office will have to discontinue further/future treatment and we will forward your records to your new Dermatologist. Therefore, by initialing this section, you are attesting that you do not have MediCal insurance. **Initials_____**

LABORATORY & PATHOLOGY SERVICES

Specimens from biopsies surgical procedures collected in our office are sent an outside laboratory or possibly pathology service for analysis. While we do our best, we cannot always determine which laboratory or pathologist are in-network with your coverage. You may be responsible for laboratory and pathology charges. Please let our office staff know if there is a designated laboratory that your insurance prefers.

MEDICAL RECORDS

Copies of your medical records may be obtained with written consent. The charge for this service is $15.00. Please keep in mind; you may be responsible for any charges incurred from any external copying services or physicians for medical records obtained.

MISSED APPOINTMENTS

Our office request a 24-hour cancellation notice for office visits and 48-hour cancellations notice for surgical procedures. **Failure to cancel an office visit will result in a $25 fee and a $75 fee for surgical or cosmetic procedures.** All cancellations/no show fees must be paid prior to having another visit with our office.

MEDICATIONS AND REFILLS

Please contact your pharmacy for prescription refills and allow at least 2 business days to process medication refill requests.

By my signature below, I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by our practice as needed.

Signature _____ **Date** _____

Patient/Responsible Party

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