Carolina Family Medicine & Dermatology, PA/
Carolina Laser and Cosmetic Center
Anne L. White, M.D.
3000 Bethesda Place Suite 601 & 602
Winston-Salem, NC 27103
336-659-2663 ● 1-877-WE BOTOX

MEDICAL PATIENT INFORMATION

Please complete all forms and sign where requested

Name: ____
Last First Middle

Address: ____
Street City State Zip

Date of Birth: ____/____/____ Age: ________ □ Male □ Female Marital Status: W M D S

Social Security Number ____-___-______

Email Address: ____
(This is important for appointment reminder / verification and/or special product offers)

Home Phone: (_____)______-__________ Business Phone: (____)_____-___________

Employer: ___________________________ Address: ____

Spouse's Name: ____________________________________ Spouse's SSN: _______-_____-_________

Emergency Contact: _________________________________ Phone Number: (_____)_______-_________

Relationship: _______________________________________

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Primary Insurance______________________ Company Address__________________________________

ID Number ___________________________ Group Number_____________________________________

Insured Name _________________________ Relationship to Patient ______________________________

Insured Date of Birth __________________________

Secondary Insurance______________________ Company Address________________________________

ID Number ___________________________ Group Number_____________________________________

Insured Name _________________________ Relationship to Patient ______________________________

Insured Date of Birth __________________________

In an emergency, whom should e notify ___________________________ Relationship ________________
Who referred you to our practice? ____

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Authorization to pay benefits to Physician: I herby authorize payment directly to the undersigned physician for the surgical and/or medical benefits. I understand that it is my responsibility to pay all charges not covered by insurance.
Authorization to release information: I hereby authorize the physician to release any medical information acquired in the course of my examination/treatment to specific insurance carriers, third party payors and others involved in processing and collection of this claim.

Patient Initials _________ Date ______________

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Our "Full Disclosure" Credit Policy

Please read before signing If you have any questions please ask our staff. They will be happy to explain and clarify any of the following information.

All payments not covered by verified health insurance are due at the time of service rendered. If for any reason, full payment cannot be made at that time, payment arrangements must be made before leaving the office. For your convenience we also take MasterCard and Visa.

We participate with most of the major insurance companies; we will file your claim as a courtesy to you. However, you will be responsible for payments on the day of service. If you have an insurance balance over 60 days old, the charges will be converted to a personal balance and you will be responsible for payment.

Unpaid balances will be referred to a collection service and will affect your credit rating. If your account is placed with our attorney, you will be responsible for any and all collection fees, usual attorney fees and any cost that this office incurs in attempting to resolve your account.

Finance charges are assessed on personal balances over 30 days old at the rate of 1.5% per month, 18% APR.

There is a **$50.00** "No Show" or "DNKA", (Did Not Keep Appointment) fee without a **24-hour cancellation** notice is not given. Insurance does not cover this, you will be responsible. If you are scheduled for a physical or an excision, please be aware the "No Show" fee is **$100.00** without **24-hour cancellation** notice, as we allow twice as much time for these procedures.

There is a $300/hour telephone consultation fee if you request a telephone consultation with Dr. White during office hours ($75 per every 15 increments). This fee will also be charged if you request a telephone consultation with Dr. White or the "on call" physician after hours. Insurance will not pay for this and you will be responsible.

Despite the forgoing information, we are happy to have you as a patient and anxious for you to understand your bill and responsibilities, and will be happy to explain any portion of it to you at any time.

For your information we would like you to be aware that we **DO NOT** participate with the following insurance company carriers:

Beech Street, Blue Cross Blue Shield (does not include BCBS State / Federal Insurance),
Cigna of NC-HMO, Partners Medicare Choice, Healthcare Savings, MedCost

We do accept Medicare, but under the conditions that the patient provides payment for services Medicare does not cover. If you have any questions please contact your insurance provider.

Patient initials________ Date____________

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Winston Salem, NC 27103

Office Collections Policy

1. **Patients are responsible for payment of their co-pay/deductible/co-insurance, at the time that services are rendered. Patients insurance will be filed immediately after their office visit.**

2. **If a patient does not have insurance then they are responsible for payment at the time that service is rendered. Credit will not be granted unless authorized in advance by the Office Manager of Dr. Anne L. White.**

3. **At 30 days patient will be notified in writing if their insurance has not paid for the services which were rendered. The patient will also be notified that they are responsible for contacting their insurance and will be responsible for paying their balance in full after 60 days.**

4. **At 60 days the patient will be billed and will hold full responsibility for payment of their account.**

5. **At 90 days the patient will receive will receive a final bill and notification/warning letter that their account will be turned over to collections if satisfactory payment arrangements are not made within 30 days from the statement date.**

6. **At 120 days the account will be turned over to collections.**

Carolina Family Medicine and Dermatology utilizes
STATEWIDE COLLECTION SERVICES

Patient Initals__________Date___________

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ACKNOWLEDGEMENT of REVIEW of PATIENT INFORMATION, CREDIT POLICY, OFFICE POLICY, and PRIVACY NOTICE

I acknowledge that I have reviewed the following information regarding Patient Information, Credit Policy, Office Policy, and Privacy Notice provided to me by Anne L. White, M.D.

I authorize Anne L. White, MD and her medical staff to speak to the following regarding my medical care.

______________________________	______________________________
Name/Relationship	Name/Relationship
______________________________	______________________________
Name/Relationship	Name/Relationship
______________________________	______________________________
Name/Relationship	Name/Relationship

______________________________	______________________________
Patient's Printed Name	Patient's Signature
______________________________	______________________________
Date	Witness Signature