Dermatology & Skin
Surgery Center, PLC

7070 E Drive North
Battle Creek, MI 49014

2121 Spring Arbor Road
Jackson, MI 49203

555 W. Crosstown Pkwy, Suite 101
Kalamazoo, MI 49008

PATIENT INSURANCE/PAYMENT INFORMATION FORM

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST
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. WE ACCEPT VISA, MASTERCARD, AND DISCOVER FOR YOUR CONVENIENCE.

I, _____, am an eligible member as of this date of service of a health plan and a copy of the benefits card is attached to this document or electronically scanned into the practice management system. Signature of responsible party below acknowledges full financial responsibility for services rendered to me, including costs, if it is determined that I am "Not Eligible" on the date of service in questions, or if service rendered is determined to be a non-covered benefit under the plan provisions.

Your signature below indicates that you understand and accept this policy. Your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

_____ _____
Signature of patient or legal guardian Date

Cardholder's Name:_____ Relationship to Patient: _____ Date of Birth: ___/___/____

Cardholder's Name:_____ Relationship to Patient: _____ Date of Birth: ___/___/____

Where should statements of your account be sent if different from above?

Name Address Apt #

City State Zip Code