

Today's Date _____

Office use – HIPPA in PP _____

PLEASE READ: The charge for dermatology is not the same as a donation for the GSC. Depending on the diagnosis, size and location of the dermatological problem is what you will be charged. We can give you insurance claim form, but payment must be made today. If you are a patient with the Good Samaritan Clinic we will not be able to see you during the dermatology clinic and you will need to call at 8:30 am on the day you wish to be seen to make a regular appt. for your dermatology problem with Dr. Teater.

DO YOU HAVE INSURANCE? _____ Company Name _____
We do not file any insurance. We can give you a completed insurance claim form for you to file yourself.

DO YOU HAVE (Red, White & Blue) MEDICARE?? YES ___ NO _____

If so please give a copy of your Medicare card to the receptionist.

The only insurance we will be filing is Medicare. We do not file ANY secondary insurance and you will be required to pay 20% of today's charges.

If you have another insurance payment must be made at time of service and we will give you completed insurance claim form for you to send to your insurance company. Thank you.

Patient Name:					
Mailing Address:					
City and State:			Zip Code:		
Home Phone:		Emergency Contact:			
Work Phone:		Emergency Contact #:			
Cellular/pager:		Pharmacy:			
Social Security #:		Occupation:			
Date of Birth:		Employer:			
Sex:	M F	Employer phone#:			
Marital Status:		Employer address:			

How do you plan to pay for today's services? CASH CHECK CREDIT CARD

HIPPA INFORMATION:

I have read and fully understand MTHC's Notice of Privacy Practices. I understand that MTHC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to access, amend, and restrict use of my medical records. I also understand that this is a summary of the complete notice and that a complete notice will be provided to me at my request. I hereby consent to the use and disclosure of my personal health information for purposes noted in this notice. I understand that I retain the right to revoke this consent by notifying the practice in writing.

Signature: _____

Date: _____

PLEASE FILL OUT THE NEXT SHEET REGARDING YOUR SKIN PROBLEM.

Mountaintop Health Care
34 Sims Circle
Waynesville, NC 28786

Dermatology Clinic

This is a FAMILY PRACTICE that has a special interest in dermatology. We have lots of experience with various rashes, moles, skin cancers, precancerous lesions, acne, and other dermatologic conditions. We are NOT Board Certified Dermatologist, but work closely with our local dermatologists to refer you if you have a difficult or dangerous condition.

NAME: _____ CHART # _____

DATE OF BIRTH:

SKIN PROBLEM:

How long have you had this problem?

WHAT PRESCRIPTION MEDICATION ARE YOU ON?

MEDICATION ALLERGIES:

OTHER COMMENTS:

HOW DID YOU HEAR ABOUT US?
