All Seasons Skin and Surgery Center, P.C.
6300 State Street Suite 2
Saginaw, MI 48603
P: 989-797-7546
F: 989-797-6007

PLEASE READ THIS PAGE CAREFULLY!

Thank you for choosing All Seasons Skin and Surgery Center. Your appointment is scheduled for:

_____at _____.

Please complete the enclosed paperwork and mail back to our office prior to your appointment. We must have the paperwork turned in at least 48 hours in advance or your appointment will be rescheduled to a later date. A 48 hour notice would be appreciated if you cannot keep your appointment.

Please bring all of your insurance cards and photo identification cards to your appointment. Any copays or outstanding balances are due at the time of your visit. You will not be seen unless these payments are made.

If you do not have insurance, all charges are due at the time of your visit.

Any insurances that require a referral must be obtained prior to your appointment from your primary care physician and a copy must be brought with you to your appointment. You will not be seen without a referral. Insurances that require a referral include Blue Care Network HMO, ASR HMO, etc.

We look forward to seeing you!

Dr. Constance Scott and staff

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed or non-cancelled appointments. A No Show/Late Cancellation is defined as missing an appointment without cancelling at least 24 hours before the scheduled time.

There will be a charge for a missed or non-cancelled appointment.

A 45.00 fee for missed appointments/late cancellations will be charged.

Repeated missed appointments may result in discharging you from the practice. We will offer 30 days of emergent care only and transfer your medical records when you find a new physician.

All Season's Skin and Surgery

6300 State St. Suite 2

Saginaw, MI 48603 989-797-7546

PATIENT INFORMATION (Please Print) Today's Date ___/___/_____

Name: _____
Last First MI

Mailing address: _____
Street City State Zip Code

Home Phone (____)_____-_____ Work Phone (____)_____-_____ Cell Phone (____)_____-_____
OK to leave message ☒ Yes ☒ No OK to leave message ☒Yes ☒No OK to leave message ☒Yes ☒ No

Date of Birth: ___/___/_____ S.S.#: ____-____-____ Marital Status: S M W D Spouse name: _____

Age: _____ Sex: M F Race: _____ Employment: FT PT FT-Student PT-Student Retired Unemployed

Occupation: _____

PARENT OR RESPONSIBLE PARTY (If different from patient) Email Address: _____

Name: _____
Last First MI

Mailing address: _____
Street City State Zip Code

Home Phone (____)_____-_____ Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Date of Birth: ___/___/_____ S.S.#: ____-____-____ Age: _____ Sex: M F Relation: _____

INSURANCE INFORMATION (Please bring your insurance card, along with a photo ID, to your appointment)

Primary insurance co. name: _____ Secondary insurance co. name: _____

Name of insured: _____ Name of insured: _____

Address of insured (if different) _____ Address of insured (if different) _____

_____ _____

Date of Birth of Insured: _____ Date of Birth of Insured: _____

Employer name: _____ Employer name: _____

Relationship of patient to insured: _____ Relationship of patient to insured: _____

Contract #: _____ Contract #: _____

Group #: _____ Group #: _____

In case of Emergency, who should be notified? _____ Phone (____)_____-_____

Can we discuss your medical conditions with other members of your household? Yes / No Specify: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are ina n insurance plan in which we participate. For those patients, applicable copayments will be collected. We accept payment in the form of cash or credit. Please note that any procedure performed in the office may be billed separately and in addition to the office visit fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or responsible party signature: _____ Date: ___/___/_____

If patient is a minor, print name of responsible party: _____ Relationship: _____