

**Westside Dermatology  
Minor Patient Registration Form**

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Home Address: \_\_\_\_\_  
Street Apt. #  
\_\_\_\_\_  
City State Zip

Child's Social Security #: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
 If student: \_\_\_ Full Time \_\_\_ Part Time Name of School: \_\_\_\_\_  
\_\_\_\_\_

Insured Parent/Guardian Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
Month Day Year

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_  
\_\_\_\_\_

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 AMERICAN EXPRESS FOR YOUR CONVENIENCE.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes **Westside Dermatology** to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to our office when an assigned claim is filed.

It is policy of this office that the adult presenting the dependent child for treatment is responsible for payment of the patient portion at the time of service.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Insurance policy owner

Relationship to minor: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Do we have your permission to:**

- Leave a message on your answering machine at home? \_\_\_ YES \_\_\_ NO
- Leave a message at your place of employment? \_\_\_ YES \_\_\_ NO
- Discuss your medical condition with any member of your household? \_\_\_ YES \_\_\_ NO

If yes, whom: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Parent/ Legal Guardian Signature

\_\_\_\_\_  
Date

**Please present insurance cards and photo ID to the receptionist so copies may be made.**

*Please Read & Sign Back*

**WESTSIDE DERMATOLOGY, LLC**  
**1410-B JOHN B. WHITE SR. BLVD.**  
**SPARTANBURG, SC 29306**

**Welcome.** It is our pleasure to serve the Spartanburg community. Please read the following office policies. If you have any questions please ask a staff member. A copy of this form is available upon request.

**Cancellation Policy.** If you must cancel your appointment, you must notify the office **24 hours** in advance. **Failure to notify the office or failure to keep your appointment may result in a \$20 charge.** Our office calls patients 2 days before their appointment, if you do not wish to receive this call please tell the receptionist.

**Insurance.** We participate with Medicare and a number of managed care plans (but not all). Please check with the receptionist regarding your insurance. **All co-payments and deductibles are to be paid at the time of service.** We do accept Medicare assignment however; the patient is responsible for the deductible and the 20% co-insurance.

**Medicaid & Workers' Compensation.** We do not participate with Medicaid nor do we take Workers' Compensation.

**Payment.** Payment for physician services is due at the time service is rendered, unless other arrangements have been made. You will receive a copy of your bill to submit to your insurance company.

**Penalties & Fees for Office Billing.** Once insurance companies have settled your claim, you will receive a bill for any balance which is considered the "patient's responsibility." This may include deductibles, co-payments/coinsurance not paid at the time of service, and any cosmetic/medically unnecessary services denied by Medicare or any other insurance company. **Please pay your bill promptly. Second and subsequent bills will be charged a \$5 re-billing fee.** Unpaid bills will be turned over for collection. If you need to make payment arrangements or have a question regarding your bill, please call the office during business hours.

**Returned Check Charge.** There will be a \$20 service charge on all returned checks.

**Dispensed Products.** All over-the-counter products are to be paid for at the time they are purchased. **NO EXCEPTIONS!!** You may request a receipt. Products can be purchased without having an appointment. **ABSOLUTELY NO REFUNDS WILL BE GIVEN ON PRODUCTS.**

**Lab Charges.** Specimens sent to outside laboratories will generate charges. You may receive a bill from the lab. **It is the patient's responsibility to inform the nurse if your insurance requires a certain lab to be used.**

Please take time to read our patient privacy policies posted in our waiting room. A copy is available at the patient's request.

**I have read the above office policies and understand the conditions concerning these policies.**

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date