Dermatology Associates of Coastal Carolina

Insurance Update Form

Patient Name: _____ Chart Number: _____

Patient DOB: _____

Thank you for choosing Dermatology Associates of Coastal Carolina.

Our goal is to avoid any miscommunication or concerns patients may have regarding our Patient Financial Policy. Thus, we would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by our office. If you have any additional questions, do not hesitate to ask any member of our team.

As a courtesy we're glad to file insurance for you. By signing this document, you are agreeing to the following: I authorize DERMATOLOGY ASSOCIATES OF COASTAL CAROLINA to perform any services necessary for proper treatment. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that as the patient, I am responsible for providing the correct active medical insurance at the time of service for DERMATOLOGY ASSOCIATES OF COASTAL CAROLINA to bill my insurance policy(s). I understand that I will be responsible for any services rendered if the accurate insurance is not provided within the timely limits for the insurance company. It is crucial to provide ALL active Medical policies at the time of service to avoid any unexpected bills. I have received and read the NOTICE OF PRIVACY PRACTICES prior to signing this consent.

Guarantor/Responsible Party:

Relationship to patient: _____

Responsible Party Name: _____ Responsible Party DOB: _____

Responsible Party Mailing Address: _____

Responsible Party Contact Number: _____ Work Home Cell

Insurance Information:

Primary Insurance Policy Payer Name: _____

Policy ID/Member ID: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address: _____

Secondary Insurance Policy Payer Name: _____

Policy ID/Member ID: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address: _____

Tertiary Insurance Policy Payer Name: _____

Policy ID/Member ID: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address: _____

_____ _____ _____/_____/_____

Patient or Guardian's Signature Relationship to Patient Today's Date

Kinston, NC 28501
Phone: (252) 686-0991
Fax: (252) 686-6810

Morehead City, NC 28557
Phone: (252) 622-4378
Fax: (252) 622-4659

Jacksonville, NC 28546
Phone: (910) 333-9337
Fax: (910) 333-8607

New Bern, NC 28560
Phone: (252) 633-4461
Fax: (252) 633-6016