**One Scobee Circle, Plymouth, MA 02360** **223 Chief Justice Cushing Hwy, Cohasset, MA 02025**
**Tel: 508-747-0711 Fax: 508-746-9265** **Tel: 781-383-3340 Fax: 781-383-3341**

**Patient First Name:** **Middle Initial:** **Last Name:**
**Address:**
**Home Phone:** **Work Phone:** **Cell Phone:**

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**Date of Birth:** **Age:** **Social Security Number:**
**Marital Status:** **Language:** **Race:** **Ethnicity**
**Primary Care MD Name:** **Primary Care MD City/Town:**

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**Responsibility Party:**
**Name:**
**Address:** **Phone:**

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**<u>Insurance Information:</u>**

| | |
|---|---|
| **Primary Insurance:** | **Secondary Insurance:** |
| **Address:** | **Address:** |
| **Subscriber Name:** | **Subscriber Name:** |
| **Relation To Patient :** | **Relation To Patient :** |
| **Subscriber ID:** | **Subscriber ID:** |
| **Group Number:** | **Group Number:** |

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**Emergency Contact Name:** **Relation:** **Phone Number:**
**Pharmacy Name:** **Pharmacy Location:**

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**Insurance Release and Acknowledgement of Financial Obligation**

I hereby authorize release of information requested by my insurance company to process claims for medical benefits and I ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, to South Shore Skin Center for services provided. I certify that the information I furnish is true and correct. *I understand that I am financially responsible for all charges to my account irrespective of my assignment of benefits. I also understand that balance more than sixty days overdue will be subject to a monthly finance charge of 1.5% per month and costs of collection.*

Date_______________ Signature of Patient or Legal Guardian_______________________________

**Receipt Of Notice Of Privacy Practices -- Acknowledgment Form**

I hereby acknowledge that on _____________________I was offered or received a copy of South Shore Skin Center's Notice of Privacy Practices, which sets forth the ways in which my personal health information may be used or disclosed by South Shore Skin Center, and outlines my rights with respect to such information.

Date_________________Signature of Patient or Legal Guardian____________________________