Completed by (initial & date) _____ MD: RKT ET DE DORA

PATIENT REGISTRATION INFORMATION

Appt Date: _____ Time: _____

Patient Name (Last) _____ (First) _____ M.I.____ Title_____ Date of Birth_____ Age____

Home Address _____ City/State/Zip _____

Home Phone _____ Cell Phone# _____ Email Address _____

Patient's Employer_____ Work Address _____ Work Phone_____

Social Security # _____ Status: Minor [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ]

Spouse's Name _____ Spouse's Employer/Work Address _____

Spouse's Work Phone_____ Spouse's Cell Phone _____ Spouse's Home Phone _____

If patient is a minor or student: Parent's Name (Guarantor) _____ Parent's Address _____

Parent's Home Phone _____ Parent's Cell Phone _____ Other Emergency Contact#_____

Family Physician _____ Pharmacy Name/Phone #_____

Referred by _____ Best Place/Time to Reach You _____

PAYMENT INFORMATION

OFFICE POLICY: **If you do not have a referral at the time of your visit, you may be asked to reschedule your appointment. Due to the high cost of billing, payment is expected at the time of your visit or procedure, unless other arrangements have been discussed with our staff. We appreciate your cooperation in settling your account at each office visit, including any co-payments, deductibles, unpaid medicare or insurance balances, and charges for cosmetic procedures or skin products.**

Who is responsible for payment of your account in our office? (Circle ONE of the following)

1) Self 2) Parent 3) Spouse (Name /Address if different than above) _____

4) Insurance Plan or HMO: (Name of Insurance Company & Policy # Information) _____

5) No Insurance _____

(To help us submit any insurance claims or lab specimens accurately for optimal reimbursement to you or to our office, please present your Insurance card to our reception desk for verification/validation.)

ACKNOWLEDGEMENT & CONSENT

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care (including HIV information) to third party payers and/or other health practitioners.
- I authorize and request that my insurance company pay directly to the doctor (s) insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to my dependents or to me.
- I also understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary, or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or to me.
- For routine office visits and full skin exams, I understand that there may be an administrative charge for any missed appointments or cancellations within 2 hours of the appointment time, and that deposits may be required thereafter to guarantee any future appointment times. I understand that there will be deposits required for most cosmetic procedures.
- I understand that I will be responsible for payments of all services rendered to my dependents or to me if I do not obtain a referral required by my insurance carrier. A valid current insurance card is required at each visit.

X _____ _____ _____

Signature of Patient or Parent/Relation Representative | Print Name of Patient or Personal Representative | Date

- I acknowledge that I have received a copy of this office's ***NOTICE OF PRIVACY PRACTICES*** **(HIPAA Rules)**. I consent to the use and disclosure of my medical information to treat me and arrange for my medical care, to seek and receive payment for the services given to me, and for the business operations of this medical office.

X _____ _____ _____

Signature of Patient or Parent/Relation Representative | Print Name of Patient or Personal Representative | Date