Dermatology Associates, Inc.

Please Print
Appointment Date and Time_____ Chart #_____

REGISTRATION FORM

Patient Name_____
Last *First* *Middle* *Maiden*

Permanent Address
(not P.O. Box)_____
Street *City* *State* *ZIP*

Mailing Address (if different)_____

Home Phone #_____Cell Phone #_____Work Phone #_____

Email Address_____

Place of Employment or School_____
Name *City* *State* *ZIP*

Birth Date_____/_____/_____ Sex: M ❑ F ❑ Soc. Sec. #_____

Patient Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Primary Care Physician
_____
_____

Insurance Company_____

Insurance Cardholders Name _____

Cardholders Birth Date_____

Cardholders Soc. Sec. #_____

Cardholders Employer_____

Patient Relationship to Cardholder _____

If a minor, please fill in responsible party information below.

Responsible Party_____

Relationship_____

Address if different from above

_____

Race	**Ethnicity**
___Caucasian/White	___Latino/Hispanic
___African American/Black	___Other
___Asian	___Not Reported/Refused
___Other	Language Spoken_____

AUTHORIZATION TO TREAT MINOR

I authorize the doctors of Dermatology Associates, Inc. to treat and prescribe medication to:

_____
Minor Child *Relationship to Minor*

_____
Signature *Date*

Authorizer's Social Security_____

Emergency Contact_____
(not at same address) *Name* *Relationship* *Phone #*

PLEASE READ & SIGN INSURANCE and FINANCIAL POLICY ON BACK!

Dermatology Associates, Inc. Financial Policies

Co-Payments: As a provider, your insurance requires that we collect your designated co-pay. Please be prepared to pay the co-pay at each visit.

Non-Participating Insurance Plans: For regular office visits, filing is the responsibility of the patient. We ask for payment in full at the time of service. As a courtesy, we will submit charges to your insurance company as a non-participating provider for surgical procedures. Any outstanding balance will be your responsibility.

Self-Pay: Self-pay accounts shall exist if you have no insurance coverage. Payment is due at the time of service.

Extended Payment Plans: As with any other industry, payment of outstanding balances is expected in full. Physician offices are not lending institutions. If credit has been extended, please understand that any patient due balance not paid within 60 days will be turned over to our collection service.

Child Custody Cases: The individual that signs for services will be responsible for all outstanding charges and balances.

Returned Check Fees: Our returned check fee (for insufficient funds) is $35.00.

Methods of Payment Accepted: Cash, Personal checks, MasterCard, Visa, Discover, and Debit Cards.

If you have any billing questions, please contact our Billing Department: 540-667-4499; Extension 108 or 110, between the hours 11am – 12noon or 2pm – 4:30pm.

Insurance and Financial Agreement

I certify that the information reported with regard to insurance coverage is correct. I agree that if incorrect or incomplete information results in claims being denied that I am responsible for those charges.

I authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier, or, in the case of Medicare Part B Benefits, to the Social Security Administration and Health Care Financing Administration.

I hereby authorize Dermatology Associates, Inc. to apply for benefits on my behalf for covered services rendered and authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Dermatology Associates, Inc. for services rendered.

I understand and agree that I am financially responsible for charges not paid by my insurance company. I understand that accounts may be forwarded for collection when not paid (1) within sixty days from the date services are rendered if I have no insurance or (2) within 60 days from the date services are transferred to patient responsibility if I have insurance in force.

I agree to cancel office visits 24 hours in advance and surgical visits 48 hour in advance if unable to keep a scheduled appointment. I understand there is a $50.00 charge for any office visit and a $75.00 - $200.00 charge for any surgery appointment not canceled. I further understand that these charges are patient responsibility and cannot be billed to the insurance company.

A copy of this authorization may be used in place of the original. This authorization may be revoked in writing by me or my insurance carrier at any time. I have read, understand, and agree to all of the foregoing terms and acknowledge receipt of a copy of same, if so requested.

X _____ Date _____
Signature of Patient, Insured, Beneficiary, or Responsible Party*

*Responsibility party's relationship to patient _____