PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name	**(Ms/Mr/Mrs/Dr)**	
Address	**Street**	
	City	
	State	
	Zip	
Email		
Preferred Language		
Social Security #		
Date of Birth		
Primary Phone	☐Home ☐Work ☐Cell **#**	
Secondary Phone	☐Home ☐Work ☐Cell **#**	
Gender	☐Male ☐Female	
Race	☐White ☐Black or African American ☐Asian ☐Native American ☐Other/Unspecified	
Ethnicity	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to provide	
Marital Status	☐Married ☐Single ☐Widowed ☐Divorced ☐Legally Separated	
If Patient is a Minor	Name of Parent/ Guardian	
	Address of Parent/Guardian (if different from above)	
Emergency Contact		

PRIMARY AND REFERRING PHYSICIANS

Physician	Name	Address	Phone
Primary Care Physician			
Referring Physician			

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of primary cardholder	Name of cardholder
Date of Birth	Date of Birth
SS#	SS#
Relationship to patient: ☐Self ☐Spouse ☐Dependent	Relationship to patient: ☐Self ☐Spouse ☐Dependent

I request that payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to Brinton Lake Dermatology (BLD) for services furnished to me by said provider. I authorize BLD to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under my insurance guidelines, a necessary service is determined to be non-covered, and I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Insurance Carrier. I authorize release of medical information for treatment, payment and healthcare operations.

Signature: _____ **Date:** _____

PLEASE COMPLETE ALL FIVE PAGES!!!!!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE & CONSENT TO USE & DISCLOSE HEALTH INFORMATION

(Read before signing the Acknowledgement and Consent)

This acknowledgement of notice and consent authorizes Brinton Lake Dermatology to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices: Brinton Lake Dermatology has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. **You may review our current notice prior to signing this acknowledgement and consent.**

Amendment: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Acknowledgement and Consent: I have received the Notice of Privacy Practices for Brinton Lake Dermatology. Brinton Lake Dermatology is authorized to use and disclose health information about me to (i.e., spouse, parent, primary physician):

_____

I authorize messages, to include all biopsy results and appointment reminders be left at this phone number: _____

X_____

Signature of Patient/Patient Representative Date Signed

ABOUT OUR PHYSICIAN ASSISTANTS AND NURSE PRACTIONERS

We are a team of physicians, physician assistants, nurse practitioners and aestheticians devoted to the diagnosis and treatment of skin conditions and diseases. We work together to provide comprehensive care of your skin.

While you are receiving care in our practice, an appointment may be scheduled with a physician assistant (PA). If so, you will be told prior to your scheduled visit. Physician assistants are licensed by the Pennsylvania State Medical Board to practice medicine under physician supervision. PAs usually have a four-year undergraduate degree and then attend two years of graduate school to become a physician assistant. FOR MORE INFORMATION ON OUR PHYSICIAN ASSISTANTS PLEASE INQUIRE AT THE FRONT DESK.

Your signature below indicates your understanding of the Physician Assistant or Nurse Practioner's role in our practice.

X_____

Signature of Patient/Patient Representative Date Signed

PAYMENT POLICY

Payment of all co-pays is due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances. For your convenience, we accept credit cards including Visa, MasterCard, American Express, and Debit Cards. Due to the constant changes in health insurance it is your responsibility to know your health coverage. If you should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you. Our mission is to provide you with the highest quality dermatological care possible. With this in mind we are constantly trying to control our costs while conforming to the standard fee schedules approved by most major insurance companies. Our receptionist will need to verify your insurance coverage prior to your visit.

1. Your medical insurance card and personal identification must be presented to the receptionist at each visit.
2. Any **outstanding balances** should be paid **before** your office visit or procedure, unless prior payment arrangements have been made.
3. Your insurance is a contract between you and the insurance company. While we accept the reimbursement rates of many insurance companies, we are not a party to your contract and do not determine which are medically necessary services that they cover and which they do not.
4. Our relationship and treatment responsibility is with/to you. We will attempt to notify you whenever we know a test or service is not covered. There will, however, be times when we cannot determine this. Whether covered or not, you are ultimately responsible for payment of the services received.
5. We require payment in full on the date of service for co-pay and offices charges defined under your policy as your responsibility.
6. A **$15 administrative fee** for delayed payment will be added to your balance if you choose not to pay at the time services are rendered. This $15 fee is not billable to your insurance company; it is your responsibility. To avoid this fee, you must pay at the time of service.
7. We expect you to call us if you are not able to make it your appointment. For your convenience, we may make an attempt to remind you of your appointment. **Your appointment is a reservation of the offices', staff's and doctor's time and resources. A charge of $60 for office visits will be made for appointments that are not cancelled 24 hours in advance… and $100 to $150 for any 30 minute or more surgical or**

cosmetic appointment. We realize that on occasion, temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance. I have read and understand the terms listed above.

X_____

Signature of Patient/Patient Representative Date Signed