PATIENT REGISTRATION FORM

TODAY'S DATE

PATIENT INFORMATION

NAME____
LAST FIRST MI

ADDRESS____APT:_____

CITY_______________________STATE_________ZIP___________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

BIRTHDATE __________________________ SEX: ☐ M ☐ F

SOCIAL SECURITY # ________________________________

PRIMARY PHONE (____) ______________________________

SECONDARY PHONE (____) ___________________________

WORK PHONE (____) ________________________________

EMAIL ADDRESS ____________________________________

Refering Doctor____________________________________
LAST FIRST

Refering Doctor's Phone #___________________________

DOES YOUR INSURANCE REQUIRE A REFERRAL LETTER?
IF YES, HAVE YOU PROVIDED THE REFERRAL? ☐ YES ☐ NO

INSURANCE INFORMATION

PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARD AND CO-PAYMENT.
DEBIT & CREDIT CARDS ACCEPTED

PRIMARY INSURANCE

INSURANCE NAME__________________________________

SUBSCRIBER NAME_________________________________

SUBSCRIBER'S EMPLOYER____________________________

SUBSCRIBER'S BIRTHDATE___________________SEX: ☐ M ☐ F

COPAYMENT_______________________________________

SECONDARY INSURANCE

INSURANCE NAME__________________________________

SUBSCRIBER NAME_________________________________

SUBSCRIBER'S EMPLOYER____________________________

SUBSCRIBER'S BIRTHDATE_________________SEX: ☐ M ☐ F

COPAYMENT_______________________________________

EMERGENCY INFORMATION AND RELEASE
IN CASE OF AN EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED

NAME____

HOME PHONE: (____) ________________________________

RELATIONSHIP_____________________________________

CELL PHONE: (____) _________________________________

I assign and authorize insurance benefits to be paid directly to Bellevue Dermatology Clinic. I also understand that I am fin ancially responsible for any balance due. I authorize release of medical information to my insurance company. I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE_______________________________________

DATE____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

WE BILL ONLY THE INSURANCE COMPANIES WITH WHOM WE HAVE CONTRACTS. WE WILL GIVE YOU A COPY OF YOUR CHARGES TO SUBMIT TO YOUR INSURANCE COMPANY IF IT IS ONE WE DO NOT BILL. IN THIS CASE, PAYMENTS ARE DUE AT THE TIME OF SERVICE. PAYMENT IS ALSO DUE AT THE TIME OF SERVICE FOR ALL COSMETIC PROCEDURES. A 1% REBILLING FEE WILL BE ADDED TO BALANCES 60 DAYS AND OLDER. A FEE OF $25 WILL BE CHARGED FOR ANY CHECKS RETURNED BY THE BANK.

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL OR PRIOR AUTHORIZATION FOR TREATMENT, IT IS YOUR RESPONSIBILITY TO SEE THAT THESE REQUIREMENTS ARE MET. IF THESE REQUIREMENTS ARE NOT MET, THEN ANY CHARGES INCURRED WILL BE YOUR RESPONSIBILITY.

WITH MY SIGNATURE, I ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENT AND AGREE TO PAY ALL CHARGES WITHIN 60 DAYS OF RECEIPT OF STATEMENT UNLESS OTHER ARRANGEMENTS ARE MADE. I UNDERSTAND THAT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT IS NOW IN PLACETO PROTECT MY MEDICAL RECORDS, AND THAT THE RECEPTIONIST WILL PROVIDE ME WITH A COPY OF THE OFFICE PRIVACY POLICY UPON REQUEST. I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED TO PROCESS MY INSURANCE CLAIMS AND AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO MY DOCTOR’S OFFICE.

HEALTH CARE INFORMATION MAY BE RELEASED TO (NEXT OF KIN): ______________________________

SIGNATURE:____**DATE:** _______________