PATIENT REGISTRATION FORM **TODAY'S DATE**

PATIENT INFORMATION

NAME_____
LAST FIRST MI

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE (____) _____

CELL PHONE (____) _____

WORK PHONE (____) _____

BIRTHDATE _____

SEX: ☐ M ☐ F ☐ Other_____

EMAIL ADDRESS _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

INSURANCE INFORMATION

INSURANCE POLICY HOLDER (*IF DIFFERENT FROM PATIENT*):

PATIENT RELATIONSHIP TO SUBSCRIBER: (*CIRCLE ONE*): SPOUSE CHILD OTHER:_____

PRIMARY INSURANCE POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INSURANCE POLICY HOLDER NAME: _____DOB: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR (*IF APPLICABLE*): _____

PREFERRED LANGUAGE: ☐ DECLINE TO SPECIFY ☐ ENGLISH ☐ SPANISH ☐ OTHER
ETHNIC GROUP: ☐ DECLINE TO SPECIFY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNKNOWN
RACE: ☐ DECLINE TO SPECIFY ☐ WHITE ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ OTHER

EMERGENCY CONTACT (*IN CASE OF AN EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED*)

FULL NAME_____ PHONE: (____) _____

RELEASE OF MY PROTECTED HEALTH INFORMATION: ☐ DECLINE

I GIVE MY PERMISSION TO THE FOLLOWING PERSON(S) TO SPEAK WITH ANYONE FROM BELLEVUE DERMATOLOGY ABOUT MY HEALTH CONDITION, BILLING INFORMATION, AND ANY OTHER RELEVANT INFORMATION. ***EXPIRES 3 YEARS FROM DATE OF SIGNATURE.***

NAME: _____PHONE: _____RELATION TO PATIENT: _____

I assign and authorize insurance benefits to be paid directly to Bellevue Dermatology Clinic. I also understand that I am financially 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**_____

Patient Financial Responsibilities

Bellevue Dermatology is committed to providing you with the highest quality medical care. Since patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful.

- You are responsible for payment of services you receive in our office. Please understand that your medical insurance is a contract between you and your insurance company. You are responsible for any unpaid balance.
- If your insurance carrier does not pay for the services, please do not ask us to change codes. We follow strict coding guidelines by the American Medical Association as well as those established and covered by federal and state programs. We will gladly bill your insurance company with the appropriate charges and diagnosis codes.
- If you are a self-pay patient, your balance will be collected in full at the time of service.
- Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification and insurance cards, as well as knowing your insurance benefits and limitations
- Obtaining authorization for your visit if it is required by your insurance, including obtaining a referral.
- Providing us with at least 24 hours' notice should you need to cancel or reschedule an appointment.

Payment Policy:

- **Medicare, HMO, PPO, or Other managed care patients:** You will be responsible for paying your annual deductible, copayment, and charges for any non-covered, cosmetic services at the time of service.
- **Referrals-** It is your responsibility to make sure your primary care doctor has provided a referral to your insurance company. Many plans upload referrals for specialists to an online portal we cannot access, therefore, we cannot know if you have a valid referral on file.
    - If your insurance requires a referral and we do not have it on file at the time of your visit, we will ask you to sign a billing waiver stating you acknowledge that your insurance company may not pay for this visit and you will be responsible for the balance.
- **Insured Patients-** We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance with us, you must notify our business office and make payment arrangements.
    - **Co-Pays/Deductibles/Co-Insurance** – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., tests, labs, etc.) will be billed separately from the office visit.
    - **Non-Participating Insurance** – If we do not participate with your insurance, you will be required to pay for your visit in full on the date of service. We will file a claim with your insurance as a courtesy. If your insurance pays a portion of the claim we submit, we will refund you the amount they paid.
- **Uninsured Patients**
    - **Office Visits** – We require that you pay the full amount of your visit on the date of services. Office procedures (e.g., labs, tests, etc.) will be billed separately from the office visit.
    - **Billing Waiver**- We may ask you to sign a billing waiver at your visit to verify you understand our policy.
    - **Other Charges- No Show** – Please provide us with at least 24 hours' notice if you need to cancel or reschedule an appointment. After 2 no shows we reserve the right to charge $50 for a missed visit or refuse services.
    - **Payment Options** – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third-party checks). We charge a $20.00 NSF fee for any returned checks.
- **Patients that need Interpreter services:**
    - **Fees-** We may charge you a cancellation fee of $50.00.

Receipt of Notice of Privacy Practices and Financial Policy:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) and the Financial Policy.

Patient or Responsible Party Signature:

_____Date_____/_____/_____