Dermatology boutique

Patient Registration Form

Name _____ Today's date _____
Last **First** **M.I.**

Mailing Address _____
Number, Street, Apartment Number

_____
City **State** **Zip**

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____) _____

Email: _____
Required for patient portal

Subscribe to the doctor's email newsletter? ☐Yes ☐No

Birth Date _____ Marital Status _____ Gender _____

Person to notify in case of emergency _____ Phone _____

Referring Doctor _____

May we discuss your medical condition with another person? ☐Y ☐N

If yes, print name_____ Relationship _____Phone # _____

How did you hear about our practice? ☐Insurance Plan ☐Family ☐Friend_____

☐Internet Search ☐Advertisement ☐Review site_____ ☐Other _____

Patient Signature _____

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If patient is a minor please enter responsible party below.
(Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Parent or guardian name (please print)_____

Parent or guardian signature _____

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
    - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
    - Co-payments are due at time of service.
    - If my plan requires a referral, I must obtain it prior to my visit.
    - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to (PROVIDER OR GROUP NAME) on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**
   I hereby authorize (PROVIDER OR GROUP NAME) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**
   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (PROVIDER OR GROUP NAME). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

I understand that I am financially responsible for any charges not paid for by my insurance or those that are not covered by my insurance.

Signature of Patient, Authorized Representative or Responsible Party	Date
Print Name of Patient, Authorized Representative or Responsible Party	Relationship to Patient

Dermatology Boutique

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing Dermatology Boutique for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____
Signature of Patient/Legal Representative)

_____
Date

_____ _____ _____
Signature of Staff Member Title Date

No Recording -- to Ensure Patient Privacy

To ensure the privacy of all my patients' information, I wanted to make you aware that I do not allow patients to do video or audio recording in my office or in exam rooms. This includes digital recordings with smartphones.

This protects the privacy of all my patients and staff, in compliance with federal and state privacy laws.

Comments: