



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 (\_\_\_\_) \_\_\_\_\_

May we send you a text message? (Regarding your appointment or to alert you of lab results, etc.) Yes No

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 the 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.

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Signature of Patient, Authorized Representative or Responsible Party

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Date

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Print Name of Patient, Authorized Representative or Responsible Party

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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:**