



Patient Registration Form

Patient (Legal) Last Name		Patient (Legal) First Name		Full Middle Name		Preferred Name		
Patient's Address (Number, Street, Apt #)				City		State	Zip Code	
<i>Billing Address (if same as above, leave blank)</i>								
Patient's Address (Number, Street, Apt #)				City		State	Zip Code	
Preferred Phone		Home		Cell	Work	Other:		
1st Alternate Phone		Home		Cell	Work	Other:		
2nd Alternate Phone		Home		Cell	Work	Other:		
Email Address								
Marital Status (circle one)			Date of Birth			Gender		
Single	Married	Divorced	Widow				Female	Male
Social Security Number		Preferred Language			Referring or Primary Care Physician			
Ethnicity (circle one)		Hispanic or Latino / Non-Hispanic or Latino / Unknown						
Race (circle one)		American Indian or Alaska Native / Asian / Black or African American						
		Native Hawaiian or Other Pacific Islander / Caucasian / Other / Decline to State or Unknown						
How did you hear about us?								

Emergency Contact

Emergency Contact's Name		Relationship to Patient		Phone	

Health Insurance Information

Health Plan Information		Primary Health Plan		Secondary Health Plan		Tertiary Health Plan	
Insurance Name							
Health Plan Address							
ID number							
Subscriber Name / DOB							
Relationship to Subscriber							
Group Number							

Patient Signature

Print Name

Guardian Signature (if patient is under 18)

Print Name

Relationship



Patient Full Name: _____ Date of Birth: _____

Consent for Treatment

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments, which my attending provider and I agree, are necessary. This consent shall remain in effect until I choose to revoke it in writing.

(Minors Only) I agree to immediately notify Deerfield Dermatology, in writing, of any of the following legal status changes between my minor and myself - loss of Parental Rights - Change in Guardianship - Divorce with loss of visitation rights.

Patient Signature

Print Name

Guardian Signature (if patient is under 18)

Print Name

Relationship

Acknowledgement Receipt of Notice of Privacy Practices (NOPP)

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). You may obtain a copy by contacting our office at (847) 480-0004.

Patient or Legal Representative Signature

Date

Staff Use Only: _____NOPP Offered, Pt Declined to Sign_____Emergency Situation NOPP Not Offered

Assignment of Benefits

By signing this document (below), I understand if claims are denied due to eligibility status, invalid medical group, or invalid Primary Care Physician (PCP), I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be held financially responsible for any non-covered benefits or deductibles for services, which have been provided to me. I agree to pay such amounts within 30 days of my insurance carrier processing the claim. I hereby assign my insurance carrier to make payments directly to Deerfield Dermatology. I understand that co-payments and outstanding balances are due at the time of service. We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility coverage.

It is my responsibility to understand my insurance benefits and plan coverage.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Other Financial Policies

Release of Information for Reimbursement

To the extent necessary to obtain reimbursement, the physician's office may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the physician's charges, including but not limited to , insurance companies, health care service plans, workers' compensation carriers, social security administration and peer review organizations. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. We may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Charges for the Completion of Forms and Copying Medical

There is a charge for the completion of forms and copying of medical records.

Payment Method

For your convenience, we accept Care Credit, American Express, VISA, MasterCard, Discover Card, cash and personal checks. Please make your check payable to Deerfield Dermatology. In the event that a payment is returned due to Non-Sufficient Funds, I understand that I will be assessed a \$40.00 charge.

By signing this document, I understand the Assignment of Benefits and Other Financial Policies listed above.

Patient or Legal Representative Signature

Date