New Patient Registration

COMMON DETAILS

Email address: _____ Patient : last name : _____ first name : _____ middle name : _____

I prefer to be called: _____ Your birthday: __/__/____ Age:____ Sex: ☐ Male ☐ Female SSN: ___-__-____

Home address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Home phone #: (___) - ___ - ____ How did you hear about us? _____

Whom may we thank for referring you? _____

ADULT PATIENT DETAILS

Marital status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed Cell Phone #: (___) - ___ - ____ Work Phone #: (___) - ___ - ____ Ext: ____

Driver's license number: _____

GUARDIANS AND CHILD DETAILS

Mother : last name : _____ first name : _____ middle name : _____ Birthday: __/__/____ Age:____

Home address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____ SSN: ___-__-____

Work phone #: (___) - ___ - ____ Ext: ____ Cell phone #: (___) - ___ - ____

Father : last name : _____ first name : _____ middle name : _____ Birthday: __/__/____ Age:____

Home address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____ SSN: ___-__-____

Work phone #: (___) - ___ - ____ Ext: ____ Cell phone #: (___) - ___ - ____

EMPLOYER DETAILS

Employer: _____ Employer address: _____ Apt. #: _____

City: _____ State: ____ Zip: _____

SPOUSE INFORMATION

His / Her name: _____ Employer: _____

Work Phone #: (___) - ___ - ____ Ext: ____ Cell Phone #: (___) - ___ - ____

EMERGENCY CONTACT INFORMATION FOR PATIENT IN CASE OF AN EMERGENCY

His / Her name: _____ Cell Phone #: (___) - ___ - ____ Work Phone #: (___) - ___ - ____ Ext: ____

☐ **Consent to Treat :** I hereby consent to treatment by my dermatologist and understand that it may include an examination, treatment with an oral or topical medication, or a skin procedure such as a biopsy or destruction of a skin leison. I have been made aware of the patient protected healthcare information act and the statement of privacy of practices is posted in this facility

RESPONSIBLE PARTY/INSURANCE INFORMATION

Insurance Co. name: _____ ID# :_____

Primary Insurance card holder : _____ Relationship: _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Home Phone #: (___) - ___ - ____ Cell Phone #: (___) - ___ - ____ Work Phone #: (___) - ___ - ____ Ext: ____

Insured's Birthday: __/__/____ Insured's SSN: ___-__-____ Insured's employer: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

☐ Release and Assignment of benefits: I hereby authorize the release of any and all medical information to my insurance carrier(s) or their representative, for purposes necessary in the adjudication or processing of any and all insurance claim(s) filed on my behalf & for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Daniel S. Achtman M.D./ Carmine G. McConnell M.D.

FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

YOUR INSURANCE

We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to understand their particular insurance plan and to be proactive in assuring that their claims will be paid.

If your insurance coverage changes, it is your responsibility to notify our office at the time of your appointment. Failure to do so may result in rescheduling of your appointment. In addition, we may not be a provider with your new insurance. You will then be treated as a cash patient and given a superbill in order to file your own claim.

You may receive a separate bill from an off-site laboratory (Ameripath , Southwest Dermatology, LabCorp, etc) for any lab test your physician may order. Please discuss any lab billing discrepancies with that laboratory.

CANCELLATIONS AND MISSED APPOINTMENTS

We kindly request that you give us a minimum of 24 hours notice, if you are unable to keep your appointment. Failure to do so will result in a missed appointment fee. This fee is NOT covered by your insurance plan. The missed appointment fee schedule is as follows.:

MEDICAL $50.00

SURGICAL $100.00

MEDICAL COSMETIC $50.00

In the case of a prepaid package, one session will be deducted from the package.

Returned Check Fee :

There will be a $35.00 charge for all returned checks.

Collections :

If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance.

Your insurance card and driver's license will be required at check in.

☐ I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature: _____ Date: _____