Dermatology Associates
OF MONTGOMERY, LLC

PATIENT REGISTRATION FORM

DATE _____
DOCTOR _____
REFERRING DOCTOR _____

DRIVER LICENSE # _____

PATIENT INFORMATION

Last Name _____ First _____ Middle Initial _____
Nick Name _____ Social Security # (last 4 digits) _____
Home Phone _____ Cell Phone _____ email address _____
Preferred Method of Communication (circle one) text cell phone home phone email
Date of Birth _____ Sex (circle one) M F Marital Status (circle one) S M W D Student Y N
MONTH DAY YEAR
Preferred Pharmacy _____ Phone Number _____
Primary Care Physician _____ Phone Number_____
Employer _____ Work Phone _____
Home Address _____ City _____ State _____ Zip _____
Billing Address _____ City _____ State _____ Zip _____
Other Contact (not living with you) _____ Relationship _____ Phone _____

RESPONSIBLE PARTY

Last Name _____ First _____ Middle Initial _____
Social Security # (last 4 digits) _____ Date of Birth _____ Driver License # _____
Employer _____ Work Phone _____
Home Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Medicare Y N Effective Date _____
Blue Cross PMD Y N Effective Date _____ Co-Pay Amount _____
PRIMARY Insurance _____ ID# _____ Group # _____
Insured Last Name _____ First Name _____ MI _____
Social Security # _____ Date of Birth _____ Sex (circle one) M F
Employer _____ Work Phone _____
SECONDARY Insurance _____ ID# _____ Group # _____
Insured Last Name _____ First Name _____ MI _____
Social Security # _____ Date of Birth _____ Sex (circle one) M F
Employer _____ Work Phone _____
If Patient is a Dependent, circle one NATURAL CHILD STEPCHILD FOSTER CHILD WARD OF COURT HANDICAPPED DEPENDENT

MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dermatology Associates of Montgomery, LLC. I request any holder of medical information about me to release to healthcare financing administration and is agents any information necessary to determine these benefits or the benefits for related services.

AS PHYSICIAN(S) CONTRACTED WITH THE MEDICARE PROGRAM, ONLY SERVICES THAT ARE DEFINED AS MEDICALLY NECESSARY CAN BE CHARGED TO THE MEDICARE PROGRAM.

MEDI-GAP

If I have Medicare supplemental insurance to which my Medicare carrier automatically "crosses over," I authorize benefits to be paid on my behalf for all services furnished to me.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PERSON OTHER THAN PATIENT RELATIONSHIP TO PATIENT

TEST RESULTS

I authorize the following person(s) (spouse, child, friend, etc.) to receive my test results.

_____

CONSENT AND MEDICAL RECORDS RELEASE

I consent to treatment necessary for care. I authorize the release of all medical records to other health care providers and to medical insurance companies for purposes related to treatment and/or reimbursement.

FINANCIAL RESPONSIBILITY

I, the undersigned, understand and accept responsibility for all fees not covered under insurance. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.3%), attorney fees and/or court costs, if such be necessary. Payment for cosmetic procedures is required when the procedure is scheduled or at the time of service, at the physician's discretion. There will be a $30.00 fee for missed appointments unless cancelled 24 hours in advance. If the appointment is surgical or procedural, the fee is $100.00. There is a $30.00 fee for any returned checks. I understand that Dermatology Associates of Montgomery, LLC does not accept workman's compensation insurance. I understand that if this account becomes delinquent, it could be turned over to a collection agency.

You agree, in order for us to service your account or to collect monies you may owe. Dermatology Associates of Montgomery, LLC, and/or our agents 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 emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Dermatology Associates of Montgomery, LLC, its employees and/or agents my contact me/us as described above.

_____ _____

RESPONSIBLE PAY SIGNATURE DATE