

PATIENT REGISTRATION FORM

Date _____

Name _____ Age _____ Date of Birth _____

Address _____ City/State _____ Zip _____

Home Phone _____ Daytime / Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Work Address _____ City/State _____ Zip _____

Social Security # _____ Sex: M / F Marital Status S / M / D / W

Primary Care Physician _____ Office Phone _____

Driver's License # _____ Who referred you to our office? _____

Do we have permission to: Leave a message on your answering machine at home? _____ at work? _____

Discuss your medical condition with any member of your household? _____ If yes, whom: _____

Please enter information on the person responsible for the bill if other than the patient.

Name _____ Relationship _____ Date of Birth _____

Address _____ City/State _____ Zip _____

Driver's License # _____ Employer _____

Work Address _____ City/State _____ Zip _____

Daytime / Work Phone _____ Evening Phone _____ Social Security # _____

Spouse Information (if applicable)

Name _____ Date of Birth _____ Social Security # _____

Employer _____ Work / Daytime phone _____ Cell phone _____

Work Address _____ City/State _____ Zip _____

Emergency Contact (Nearest relative or friend)

Name _____ Relationship _____ Daytime Phone _____

Insurance Information

Primary Carrier _____

Insured Name _____

Insured Date of Birth _____

Insured Employer _____

ID# _____

Group # _____

Your relationship to insured _____

Secondary Carrier _____

Insured Name _____

Insured Date of Birth _____

Insured Employer _____

ID# _____

Group # _____

Your relationship to insured _____

Patient (or Guardian Signature) _____ Date _____

Guarantor Agreement / Acknowledgement of Notice of Privacy Practices

I authorize Tricia Brown, M.D., P.A. to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Tricia Brown, M.D., P.A. I understand that Tricia Brown, M.D., P.A. will file my insurance claim as a courtesy to me, and as such, is not required to wait for extended delays in payment. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductibles, or unassigned portion of charges at this office.

I understand that Tricia Brown, M.D., P.A. does NOT automatically file to secondary insurance and I must file the claim if it does not crossover automatically from Medicare. (If your secondary insurance is an automatic crossover, Medicare will send the claim automatically to them. If not, the patient is responsible for the deductible and 20% copay at the time service is rendered. The patient will need to send the Medicare explanation of benefits to the secondary carrier.)

I have received a copy of the Notice of Privacy Practices for Tricia Brown, M.D., P.A. I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice. I know that if I do not consent, services cannot be provided to me.

I have read and understand all of the following:

- 1) Payment (in the form of cash, check or credit card [Visa, Mastercard]) is required for all services and/or copayments at the time of visit.
- 2) Returned checks will be charged a \$30 fee to cover processing and bank fees.
- 3) Overdue accounts are subject to a \$30.00 late fee after 60 days. In the event that a delinquent account must be turned over to collections, the patient is responsible for all attorney fees, court costs and collection agency fees associated with the collection process.
- 4) In order to provide the best possible service and availability to all our patients, it is office policy to charge a \$30 fee for any appointments not cancelled at least 24 hours prior. This fee is NOT covered by insurance and is the full responsibility of the patient. Please call us as early as possible if you know you will need to reschedule your appointment.
- 5) **HMO (Managed care) patients:** It is the responsibility of HMO patients to ensure that they have obtained a referral for all appointments with this office, if needed. The patient is financially responsible for any and all services rendered that are not a part of the referral, if not covered or paid by insurance. If you did not get a referral for a specialist office visit, your insurance company will require you to pay the full amount for all services.
- 6) **PPO patients:** Most insurance companies consider all dermatology procedures (such as skin biopsies or freezing off warts) to be surgical in nature. They will often apply these costs to your deductible. When we verify insurance for your appointment, we are given a general idea about your coverage, but we will not know exactly what they cover until we send off the claim and receive an explanation of benefits (EOB). It is a good idea for you to become well acquainted with the specifics of your coverage. If you want to delay a particular procedure until you know these details, the front desk staff will be happy to provide you with the appropriate medical codes for you to give to your insurance company.
- 7) **Parents of young children:** While we strive to provide a safe environment for everyone, medical exam rooms can be a dangerous place for unsupervised children. Please watch your children closely. For their safety, it is extremely important to keep them away from the medical waste trash can, the drawers and cabinets, and the Doctor's rolling stool. At your request, we can remove some of these items from the room for you.

Patient (or Guardian) Signature _____ Date _____