PATIENT REGISTRATION FORM

Date____________________________

Name____ Preferred Name___________________ Age________ Date of Birth_________________

Address____ City/State______________________ Zip___________

Cell Phone____________________________ Daytime / Work Phone_____________________________ Home Phone_______________________

Email Address____ Would you like to receive emails about specials from our office? Y / N

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?____

Please list any family members who also see Dr. Brown ____

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. 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. I understand that Tricia Brown, M.D. 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 have received a copy of the Notice of Privacy Practices for Tricia Brown, M.D. 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, Discover]) 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 regular 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. For surgery appointments, medical procedures, and cosmetic procedures, a $100 no-show fee will apply. Cosmetic surgeries and procedures require a $25-$100 deposit in order to reserve the appointment time. This will be refunded if the appointment is cancelled at least 24 hours prior.
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____________________