MID-COLUMBIA
DERMATOLOGY

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home phone no.: ( )
City:	State:	Zip Code:			Cell Phone: ( )
Email:	Employer:				Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Ins:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mid-Columbia or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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Patient Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by this clinic. As a service to you we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due at time of service, unless other financial arrangements are made. This includes deductibles, co-pays, and/or co-insurance. Established patients with a balance will be asked for payment at time of service.

I assign Mid-Columbia Dermatology all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to fees and be turned over to a collection agency.

For cosmetic procedures and skin care products, payment in full is expected at the time of each visit.

Minors: Patient under 18 years of age will be responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral from your primary care provider (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment.

Insurance Billing: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit. Charges owed due to claim rejection and/or non-response by the insurance company is the responsibility of the patient.

Medicare: Our providers are participating providers. I understand that I will be responsible for any portion determined by Medicare as "patient responsibility" and any charges not covered by Medicare will be my responsibility. Please provide staff with secondary insurance information if you have it.

Check Returns: It is our policy to charge all patients a $30.00 fee for returned checks.

Cancellation: A $30.00 fee will be charged for any appointment cancelled without 24 hours notice.

Laboratory: We send all biopsies and lab work to an outside lab. You will receive a separate bill from this company.

I am aware of the following potential complications as outlined for any procedure performed at Mid-Columbia Dermatology:
Bleeding, Nerve damage, Infection, Postoperative problems, Scarring, Pain

I am aware that if I become pregnant, I am responsible for reporting to my OB/GYN any and all prescriptions that I am using, including Isotretinoin and/or topical retinoids.

Authorization to Release Information: I have read and I accept this policy for my testing and/or treatment with Mid-Columbia Dermatology. The Notice of Privacy Practices for Mid-Columbia Dermatology is available at the clinic reception desk and I acknowledge I have seen a copy of the Notice of Privacy Practices.

I, or my appointed agent, have read, fully understand and agree to the above statements.

_____ _____ _____
Patient Name (print) Patient Signature Date

If the patient is under the age of 18, or otherwise unable to sign, complete the following:

Patient is _____ year(s) of age or is unable to sign because: _____

_____ _____ _____
Signature Relationship to Patient Date