Patient Registration Form

Patient Information

Today's Date: _____

Primary Care Physician: _____

First Name:_____Middle:_____Last:_____

Date of Birth:_____Age:_____Sex: Male Female

Address:_____

City:_____State:____Zip:_____

Home Phone:_____Work Phone:_____

Cell:_____Email:_____

Out of State Address:_____

City:_____State:____Zip:_____

Out of State Phone Number:_____

Employer Information

Patient Employer:_____Phone Number: _____

Employer's Address: _____

Occupation: _____

Parent or Responsible Party (If different from patient)

First Name:_____Middle:_____Last:_____

Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____

Emergency Contact Information

In case of emergency, who should we notify? _____

Relationship to Patient:_____Home Phone: _____

Work Phone:_____Cell Phone: _____

Regarding Your Medical Information

May we leave personal medical information on your answering machine at home? Yes No

May we discuss your medical information with family members? Yes No If yes, please fill out below:

Name:_____Relationship: _____

Name:_____Relationship: _____

I hereby certify that the information I provided on this form is true and accurate and I have read and understand the statements contained in this form.

Patient's Signature:_____Today's Date: _____

Parent/Guardian:_____Today's Date: _____

** Please present insurance cards to receptionist to scan**

Please initial the boxes below.

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf._____**[Initial]**

CONSENT TO TREAT: I hereby give Winter Haven Dermatology permission to examine me for the purpose of making a diagnosis. I further permit and request that they perform the tests and procedures they deem necessary and that they and I agree are appropriate for my medical care. _____**[Initial]**

MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carrier, any information for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. _____**[Initial]**

FINANCIAL POLICY: We are Medicare participating providers. We will bill Medicare and supplement carriers. You will be responsible at the time of service for payment of the annual deductible, coinsurance, and/or charges for non-covered services. If you have secondary coverage with a plan that we are not contracted with, we will file a claim for you. If no payment is received from your secondary, you will be sent a bill and will be responsible for the balance. If we are contracted with a commercial insurance plan under which you are covered, we will bill the carrier for all charges. You will be responsible at the time of service for payment of any deductible, copays, coinsurance, and charges for non-covered services. In the event patient and/or doctor are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier. If we are not contracted with your insurance plan, you will be responsible for the entire bill

at time of service. We will supply you with copies of the charges which you can then file with your insurance. It is your responsibility to know if your plan has out of network benefits.

_____**[Initial]**

RECEIPT OF NOTICE OF PRIVACY PRACTICES: We are required by law to provide you with a copy of our Notice of Privacy Practices. This is available upon request. _____**[Initial]**

CALLS TO OUR OFFICE: You may call our office at 863-299-3376. It is not always possible to immediately speak with your provider or nurse, as they have many responsibilities. Therefore, clinic staff will take your phone message and your call will be returned as soon as it is possible and reasonable for the urgency of the message. We appreciate your patience and understanding of this policy, as it exists to ensure that we are able to adequately devote time and attention to all patients. Non-urgent calls will most likely be returned by the end of the day. Calls received late in the day may be returned the next morning. If you have not heard back from us within 24 hours of your call please call us back to check the status of your message. Refills may require 48 hours to be processed, so please plan ahead! When requesting a refill, please provide the following information: name of medication, dosage, how often you take the medication, name of your pharmacy, phone number and fax number for your pharmacy. _____**[Initial]**