Today's Date: ___ ___ / ___ ___ / ___ ___

PATIENT REGISTRATION AND CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Sex:** *(please circle)* **Male** **Female**
Last *First* *MI*

Date of Birth: ___ ___ / ___ ___ / ___ ___ **Marital Status:** *(please circle)* **S** **M** **W** **Sep** **D** **SSN:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____
Street *Apt #* *State* *Zip*

Home Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ **Cell Phone Number:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Are You Employed? *(please circle)* **YES** **NO** **Occupation:** _____ **Employer/Company:** _____

Work Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ **Email Address**_____

Primary Care Physician Name: _____ **Phone:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
We Must Have You Primary Care Physician On Record Because We Are Specialists

Who Referred You To Our Office? **Dr.** _____ **Friend:** _____ **Other:** _____

Pharmacy of Choice: _____ **Phone:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Name *Location*

Emergency Contact Name: _____ **Relationship:** _____ **Phone:** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

PRIMARY INSURANCE INFORMATION

Primary Insurance Plan Name: _____ **Policy / ID Number:** _____

Insurance Address: _____ **Group #:** *(if applicable)* _____

Specialist Co-pay: *(please circle)* **$10** **$15** **$20** **$25** **$40** **$50** **other:** _____ **Does your primary insurance require a referral?** *(please circle)* **YES** **NO**

Name of Policy Holder: _____ **Policy Holder's SSN:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Policy Holder's Date of Birth: ___ ___ / ___ ___ / ___ ___ **Relationship to Patient:** *(please circle)* **self** **parent/caretaker** **spouse**

Policy Holder's Home Address: *(if different from patient)* _____
Street *Apt #* *State* *Zip*

SECONDARY INSURANCE INFORMATION

Secondary Insurance Plan Name: _____ **Policy / ID Number:** _____

Insurance Address: _____ **Group #:** *(if applicable)* _____

Specialist Co-pay: *(please circle)* **$10** **$15** **$18** **$20** **$25** **$40** **other:** _____ **Does your secondary insurance require a referral?** *(please circle)* **YES** **NO**

Name of Policy Holder: _____ **Policy Holder's SSN:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Policy Holder's Date of Birth: ___ ___ / ___ ___ / ___ ___ **Relationship to Patient:** *(please circle)* **self** **parent/caretaker** **spouse**

Policy Holder's Home Address: *(if different from patient)* _____
Street *Apt #* *State* *Zip*

NOTICE TO PATIENT

By signing this form I understand that I am giving my consent to Dr. Donna A. Serure, Dermatology, P.C. to use and disclose my health care information to carry out treatment, payment activities and healthcare operations of this practice. I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed, and as necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Donna A. Serure, Dermatology, P.C. to apply for benefits on my behalf for covered services rendered and request that payment from my insurance company be made directly to Dr. Donna A. Serure, Dermatology, P.C. I understand that **I am financially responsible** for all services rendered for the following reasons if: 1) I do not have the proper referral at the time of service, 2) my referral is invalid/expired, 3) I have given incorrect/invalid insurance information, 4) expenses are not covered by my insurance company, 5) I have not met my deductible, or 6) the services rendered are deemed medically unnecessary by my insurance company **(this applies to present and future visits)**. Payment is required for all services at the time they are rendered, including co-payments and any outstanding balances. In the event that your account must be turned over to collections, a $50.00 collection fee will be added to your account. We reserve the right to charge a $30.00 service fee for appointments cancelled with less than 24 hours notice. All optional services will not be performed until a consultation with the Doctor is performed and services to be rendered are explained. **All cosmetic procedures are payable by Cash or Credit Card only.** Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

_____ ___ ___ / ___ ___ / ___ ___
SIGNATURE OF PATIENT / RESPONSIBLE PARTY **TODAY'S DATE**

FOR OFFICE USE ONLY	**Both sides of insurance card attached to chart and verified by:**	FOR OFFICE USE ONLY