REGISTRATION FORM

(Please Print)

Today's date:			Patient ID:	
PATIENT INFORMATION				
Patient's Last name: First: Middle:			Sex: ❑ Male ❑ Female	Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Birth date: / /	Home phone no.: ( )	Cell phone no.: ( )	Preferred phone number: ❑ Home ❑ Cell Is it OK to leave a detailed message? ❑Yes ❑No	
Street address:			Social Security:	
P.O. Box:	City:		State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )	
Preferred Pharmacy:			Primary Care Provider (PCP):	
I authorize Avail Dermatology to access my pharmacy to coordinate my medications: □ Yes □ No				
Email address (to obtain access to our patient portal):				
Preferred method of communication (please select one): ❑ Phone ❑ Email ❑ Letter ❑ Patient portal				
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.: ( )	
Please indicate primary insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance (if applicable):	Subscriber's name:	Birth date:	Group no:	Policy no:

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

HIPAA PRIVACY ACT

I understand I can obtain a copy of Avail Dermatology's HIPAA privacy act. **X** _____
Initials

CONSENT TO TREAT

I consent to treatment rendered by the physician and his/her directed medical staff at Avail Dermatology. I understand that Avail Dermatology utilizes Physician Assistants to render health care.

With my consent, Avail Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations.

RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize Avail Dermatology to share my PHI with the following people:

Name	Phone number	Relationship to patient	I only want to share the PHI I have checked below:
1. _____	_____	_____	❑ Medical ❑ Billing ❑ ALL
2. _____	_____	_____	❑ Medical ❑ Billing ❑ ALL
3. _____	_____	_____	❑ Medical ❑ Billing ❑ ALL

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Primary phone number:

FINANCIAL POLICY

With my signature, I agree that all information I have given 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. This responsibility applies to copay, deductible, co-insurance, full payment if uninsured and for cosmetic procedures that are not covered by insurance. We do not file insurance for any cosmetic services. I also authorize Avail Dermatology or insurance company to release any information required to process my claims.

Check Policy: If your check is dishonored or returned for any reason, we will debit your account for the check plus a processing fee of $30.00.

Collection Policy: We employ an outside collection agency for delinquent accounts. Fees will be incurred for their services.

Appointment No Show Policy: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee. There will be a $50 fee for surgery/procedure appointments that are not cancelled within 24 hours; this will not be covered by your insurance company.

Waiver of Medical Necessity: Your insurance is a contract between you and your insurance company. Coverage benefits will vary based on your personal policy. Please contact them directly with any questions about your specific coverage.

Please be aware that your insurance carrier may pay all, part, or none of the cost of your services depending on your individual policy. It is the responsibility of the patient to be aware of any limitations on his or her insurance plan prior to the visit. Charges that are not covered by the patient's insurance policy will be the patient's responsibility.
In some cases, it may be necessary for your provider to provide a problem-oriented service in addition to your reason for visit. This portion of the visit will be subject to any copay, co-insurance, or deductible as required by your insurance policy. If your provider suggests any additional procedures or tests regarding a problem, these charges would also be subject to any patient responsibility as determined by your insurance.

Laboratory/pathology test processed outside of our office include biopsies and blood work. We will provide the laboratory with your insurance information and they will bill you directly for any remaining balance.

Pathology test are performed in Avail Dermatology's specialized Dermatology Lab. These charges will be filed with your insurance and you will be billed by Avail Dermatology for any remaining balance.

X _____

Patient/Guardian Signature ***Date***