Initial Patient Registration Information

Name_____ Date: _____
First Middle Last

Gender ☐ M ☐ F Date of birth: _____

Address: _____ Phone: __ __ __-__ __ __ - __ __ __ __ Cell

_____ Phone: __ __ __-__ __ __ - __ __ __ __ Home

_____ Phone: __ __ __-__ __ __ - __ __ __ __ Work

Insurance and Pharmacy

Insurance Company _____ Group # _____

Name of Policyholder _____ Policy # _____

Policyholder date of birth _____/_____/_____ Pharmacy name and location _____

Privacy and Contact Information

The Health Insurance Portability and Accountability Act (HIPAA) requires that Market Street Dermatology obtain your authorization to allow verbal communications regarding your health information. This authorization allows Market Street Dermatology to discuss your health care with a spouse, child, friend, or other family member that you designate. It also allows Market Street Dermatology to leave recorded messages at your home, work, or on your cell phone related to your medical care and treatment, payment, appointment status, or follow-up.

What is the preferred number for us to reach you?
☐ cell
☐ home
☐ work

May we leave a detailed message at any of the following numbers?
Check all that apply
☐ cell
☐ home
☐ work
☐ none

If you have results or need to be contacted, at which number may we leave a message to return our call?
Check all that apply
☐ cell
☐ home
☐ work
☐ none*

How may we remind you of appointments?
Check all that apply
☐ text message
☐ e-mail
☐ do not remind

* Please discuss with the physician how best to contact you

What is your e-mail address? _____

☐ Check here if you would like to be made aware of changes or events in our practice. We will not share your email address.

If there is anyone else that you would like us to have the ability to discuss all aspects of your protected health information, please include their information below.

Name _____ Relation _____ Phone number _____

I understand that I may refuse to sign this authorization. I realize this may result in a delay of treatment and have potential adverse health consequences. I may change or revoke this authorization at any time.

Patient or Responsible Party* Signature _____ Date ____/_____/_____

**If you signed above and are not the patient, please print name and describe relationship to patient below*

Relation to patient _____ *Printed name* _____

Initial Patient Registration Information (page 2)

Receipt of Privacy Practice

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices. I understand that I may request a paper version of this policy and that it is available to me on the website and in the office.

Patient or Responsible Party Signature _____ Date ____/_____/_____

Measurement Reporting Information

We appreciate your cooperation in providing answers to the questions below

Centers for Medicare and Medicaid Services require us to ask all patients (regardless of insurance type).

Is English your primary language? ☐ yes ☐ no If no, What is your primary language? _____

What is your race?
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Native Hawaiian or other Pacific
- ☐ Other ☐ Decine

What is your ethnicity?
- ☐ Hispanic or Latino
- ☐ Not Hispanic/Latino
- ☐ Decline

Insurance Agreement

I attest that the information I have provided to Market Street Dermatology Clinic is correct and true to the best of my knowledge.

☐ I authorize the release of any medical information acquired in the course of my treatment to my insurance company as needed to issue benefits. I also request any benefits on my behalf to be paid to Market Street Dermatology.

Patient or Responsible Party Signature _____ Date ____/_____/_____

Medicare Subscribers Only

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $147.00 deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, any remaining balance will be your responsibility.

I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of Medicare insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits applies.

Signature _____ Date ____/_____/_____

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the above MEDIGAP carrier any information needed to determine these benefits payable to related services.

Signature _____ Date ____/_____/_____

Please remember, in order for us to submit claims to your insurance, you must present any Insurance Cards (private or Medicare) and a photo ID when you check into your appointment.