Initial Patient Registration Information

Name____ **Date**: ____________________

First Middle Last

Date of Birth _____ / _____ / _____

Gender at birth ☐M ☐ F **Preferred pronouns** ☐He/Him ☐ She/Her ☐ Them/They

Address ____________________________________ **Phone:** __ __ __-__ __ __ - __ __ __ __ Cell

____________________________________ **Phone:** __ __ __-__ __ __ - __ __ __ __ Home

Pharmacy name and location ______________________ **Email** ________________________________

Insurance

Insurance Company ____________________________ Group # _________________________

Name of Policyholder ____________________________ Policy # _________________________

Policyholder date of birth _____ / _____ / _____

Privacy and Contact Preferences

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 or cell phone related to your medical care and treatment, payment, appointment status, or follow-up.

What is the preferred method for us to reach you for messages to contact our office? ☐ cell ☐ home

Can we leave a detailed message regarding your care on your **cell phone**? ☐ **Yes** ☐ **No**

Can we leave a detailed message regarding your care on you **home phone**? ☐ **Yes** ☐ **No**

Can we **text** you appointment reminders and detailed messages? ☐ **Yes** ☐ **No**

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 ☐ Decline

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.