MIDWEST DERMATOLOGY

# Patient Registration Form

| Patient (Legal) Last Name | Patient (Legal) First Name | Full Middle Name | Preferred Name |
|---|---|---|---|
| | | | |

| Patient's Address (Number, Street, Apt #) | City | State | Zip Code |
|---|---|---|---|
| | | | |

*Billing Address (if same as above, leave blank)*

| Patient's Address (Number, Street, Apt #) | City | State | Zip Code |
|---|---|---|---|
| | | | |

**Midwest Dermatology contacts patients as a courtesy to remind them of their upcoming appointments, which is covered under our Notice of Privacy Practices. We use phone call reminders to ensure our patients are given timely notification to reduce no shows or late cancellations.**

| | | | | | |
|---|---|---|---|---|---|
| Preferred Phone | | Home | Cell | Work | Other: |
| 1st Alternate Phone | | Home | Cell | Work | Other: |
| 2nd Alternate Phone | | Home | Cell | Work | Other: |
| Email Address | | | | | |

| Marital Status **(circle one)** | | | | Date of Birth | Gender | |
|---|---|---|---|---|---|---|
| Single | Married | Divorced | Widow | | Female | Male |

| Social Security Number | Preferred Language | Referring or Primary Care Physician |
|---|---|---|
| | | |

| | |
|---|---|
| Ethnicity **(circle one)** | Hispanic or Latino / Non-Hispanic or Latino / Unknown |
| Race **(circle one)** | American Indian or Alaska Native / Asian / Black or African American<br>Native Hawaiian or Other Pacific Islander / Caucasian / Other / Decline to State or Unknown |
| How did you hear about us? | |

## Emergency Contact

| Emergency Contact's Name | Relationship to Patient | Phone |
|---|---|---|
| | | |

## Employer Information

| Employer Name and Address (Number, Street, Apt #, City, State, Zip Code) | Employer Phone Number |
|---|---|
| | |

Patient Signature ______________________ Print Name ______________________

Guardian Signature (if patient is under 18) ______________________ Print Name ______________________ Relationship ______________________

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Patient Full Name: ____________________________ Date of Birth: ______________

## Consent for Treatment

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments, which my attending provider and I agree, are necessary. This consent shall remain in effect until I choose to revoke it in writing.

(Minors Only) I agree to immediately notify Midwest Dermatology, in writing, of any of the following legal status changes between my minor and myself - loss of Parental Rights - Change in Guardianship - Divorce with loss of visitation rights.

______________________________ ______________________________

Patient Signature Print Name

______________________________ ______________________________ ______________

Guardian Signature (if patient is under 18) Print Name Relationship

## Acknowledgement Receipt of Notice of Privacy Practices (NOPP)

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). You may obtain a copy on our website at www.Midwestderm.com contacting our office at (847)-394-1202.

Midwest Dermatology contacts patients to remind them of their upcoming appointments, which is covered under our notice of privacy practices. We use automated phone call reminders to ensure our patients are given timely notification to reduce no shows or late cancellations.

______________________________ ______________________________

Patient or Legal Representative Signature Date

Staff Use Only:_____NOPP Offered, Pt Declined to Sign_____Emergency Situation NOPP Not Offered

## Assignment of Benefits

By signing this document (below), I understand if claims are denied due to eligibility status, invalid medical group, or invalid Primary Care Physician (PCP), I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be held financially responsible for any non-covered benefits or deductibles for services, which have been provided to me. I agree to pay such amounts within 3 weeks of my insurance carrier processing the claim. I hereby assign my insurance carrier to make payments directly to Midwest Dermatology. I understand that co-payments and outstanding balances are due at the time of service. We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility coverage. We typically submit our office specimens to CPC Laboratories unless specifically requested at the time of service of every visit.

**It is my responsibility to understand my insurance benefits and plan coverage.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

## Other Financial Policies

### Release of Information for Reimbursement

To the extent necessary to obtain reimbursement, the physician's office may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the physician's charges, including but not limited to , insurance companies, health care service plans, workers' compensation carriers, social security administration and peer review organizations. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. We may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

### Charges for the Completion of Forms and Copying Medical

There is a charge for the completion of forms and copying of medical records.

### Payment Method

For your convenience, we accept VISA, MasterCard, Discover Card, cash and personal checks. Please make your check payable to Midwest Dermatology. In the event that a payment is returned due to Non-Sufficient Funds, I understand that I will be assessed a $40.00 charge.

### Charge for No Shows and/or Late Cancellations

The practice reserves the right to charge for patient no shows/and or late cancels. The amount charged is $35.00 and is patient responsibility.

**By signing this document, I understand the Assignment of Benefits and Other Financial Policies listed above.**

______________________________ ______________________________

Patient or Legal Representative Signature Date

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