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REGISTRATION FORM

Today's Date:	Chart #:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital Status:

Street Address:	City:	State:	ZIP Code:

Sex ☐M ☐F	Social Security #:	Date of Birth:

Mobile Phone:	Home Phone:	Work Phone:	Email Address for contact: ☐Check box if you would like promotional emails

Preferred method of communication: ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Is it ok to leave a detailed message? ☐ Yes ☐ No

PRIMARY CARE PHYSICIAN:

Name:		Address:	Phone Number:

REFERRING PHYSICIAN (IF APPLICABLE):

Name:		Address:	Phone Number:

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Phone Number: ( )

INSURANCE

Person responsible for bill:	Date of Birth:	Address (if different):	Home Phone No.: ( )

Is this person a patient here? ☐ Yes ☐ No

Primary Insurance Company:	Member Id:	Group Number:

Policy Holder's Name:	Date of Birth:	Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Name of Secondary Insurance (if applicable):	Member Id:	Group Number:

Policy Holder's Name:	Date of Birth:	Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

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Thank you for choosing our office. We are committed to providing you excellent care.

OFFICE AND FINANCIAL POLICIES

APPOINTMENTS: We require a minimum of 24 hours notice to cancel an appointment. Last minute cancellations are subject to a No Show Fee.

FINANCIAL OBLIGATIONS/INSURANCE: Please present your current insurance card(s) each time you visit our office. We participate in a limited number of insurance plans, but will happily file an insurance claim on your behalf.

If we accept your insurance, all copays, balances and uncovered services are your responsibility. Copays are payable at the time of your visit. We accept cash, checks and credit cards. In order to streamline our billing practices, once your claim is processed, any balance (as per your insurance company's explanation of benefits) will be charged to you on the credit card you provide for your account. All credit card information will be protected and a receipt will be forwarded to you if you provide an email address for same along with your credit card information. We appreciate your cooperation.

If we do not accept your insurance, payment in full is required at the time of service. Additionally, all cosmetic services require payment in full at the time of service.

In the event that we are required to send you more than one bill, an administrative fee may be added to your unpaid balance. Additionally, if we should be required to turn over your account to a collection agency, the cost of using such a service will be added to your balance due.

LAB SERVICES: By signing below, you authorize any laboratory services associated with your care. This includes the laboratory billing your insurance company directly and releasing any medical information needed to process the claim. You may receive a bill directly from the laboratory.

CONSENT FOR TREATMENT OF A MINOR: By signing below, you consent to having your child evaluated and treated in your absence (if applicable).

PRIVACY: We maintain patient confidentiality. By signing below, you authorize our office to release your information to other health care providers in connection with your care and to your insurance company to process your claim. A copy of our privacy policy is available upon request.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE POLICIES:

PATIENT NAME: _____ DATE: _____
(*Please print*)

PATIENT OR GUARDIAN SIGNATURE: _____

I AUTHORIZE THE FOLLOWING CREDIT CARD FOR PAYMENT OF MY ACCOUNT:
(Your credit card will be used for unpaid copays and balance billing, i.e., the amount due after your insurance company processes your claim, normally attributed to coinsurance and non-covered services.)

(*Please print*)

CARD TYPE: _____ (NO AMEX PLEASE)

CARD NUMBER: _____

EXPIRATION DATE: _____ SECURITY CODE: _____

NAME ON CARD: _____

EMAIL ADDRESS FOR RECEIPT: _____