

Patient Registration Form

Patient (Legal) Last Name		Patient (Legal) First Name		Full Middle Name		Preferred Name	
Patient's Address (Number, Street, Apt #)				City		State	
<i>Billing Address (if same as above, leave blank)</i>							
Patient's Address (Number, Street, Apt #)				City		State	
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 and Address			
Ethnicity (circle one)		Hispanic or Latino / Non-Hispanic or Latino / Unknown					
Race (circle one)		American Indian or Alaska Native / Asian / Black or African American 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

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.dermatologymidwest.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