

HERNDON DERMATOLOGY - Anh P. Dang-Vu., M.D., P.C.

REGISTRATION INFORMATION

Date _____ Referred
by: _____

Patient's Name (Last name): _____ (First
name): _____

Responsible party (if a minor): _____ Relation to patient:

Street Address: _____ City, State,
Zip: _____

Sex: M F Age: _____ Birth-date: _____ Single Married
 Widowed Separated Divorced

Phone(H) _____ (W) _____

Cell Phone: _____ E-
Mail _____

We would like to send you all appointment reminder via text, unless requested via email.

Occupation: _____ Patient Employed
by: _____

E m p l o y m e n t
Address: _____

Spouse's or Parent's
Name: _____

Occupation: _____ Employed
by: _____

Employment Address: _____ Phone Number:

Has anyone in your family been seen in this office?

List their
names: _____

Insurance Information (Payments/Co-pay Required at Time of Service, Unless Prior Arrangements Have
Been Made)

Insurance Company Name
Policy Number

Policyholder

1. _____

2. _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to **Dr. Anh P. Dang-Vu**, for the services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance/ Medicare.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Dr. Anh P. Dang-Vu**, to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.

RECEIPTS OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

I certify that I have received a copy of Dr. **Anh P. Dang-Vu's** Notice of Privacy Practices.

A photocopy of these assignments shall be valid as the original.

Signature: _____ (Print Name) _____

P a r e n t ' s / G u a r d i a n
Signature: _____

HERNDON DERMATOLOGY - Anh P. Dang-Vu, M.D., P.C.

INFORMATION REGARDING OUR PRACTICE

We currently participate with several insurance plans. Please check with our staff. For us to process your insurance claims properly we ask that you to provide us with adequate information. By signing the necessary forms during registration, we will be happy to file your claims for you.

If your insurance plan requires you to have a referral, it is the patient's responsibility to obtain the referral not our doctor's office. Be prepared to pay in full for your services if you arrive without a referral. It is also your responsibility to be informed as to what services your insurance plan will and will not cover. We cannot adjust charges or diagnosis codes after services have been provided. Co-pays are paid at the time of your visit. If your insurance company denies payment for your charges, your balance must be paid within 60 days. We do use a collection agency to assist in collecting unpaid balances. Any balances remaining after insurance has paid will be billed to you. There is a \$25 returned check fee.

Because your insurance policy is an agreement between you and your carrier, disputes related to your coverage are to be handled by you and your insurance company.

We ask for 24-hour notice for cancellations. We will charge a \$30 fee for appointments not kept and cancellations received the same day. Reminder calls are done only as courtesy.

Please provide our front office staff with accurate and up to date information. By doing so we can process your claims more efficiently. Most importantly, please fill out your patient information neatly. If we cannot read your hand-writing we cannot contact or accurately file your claims for reimbursement.

PATIENT FINANCIAL AGREEMENT

I hereby authorize **ANH P. DANG-VU, MD, PC** to apply for benefits on my behalf for services rendered. I certify that the information I have reported about my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance company to determine these benefits payable. I request that payment of authorized benefits to be made to **ANH P. DANG-VU, MD, PC** on my behalf. I further acknowledge and understand the following:

1. **ANH P. DANG-VU, MD, PC** participates with certain HMO/PPO programs. If I am covered by an HMO or PPO that the office participates with, I agree to pay my co-payment at the time of service.
2. Commercial insurance participants may be required to pay in full for charges at time of service. As a courtesy, **ANH P. DANG-VU, MD, PC** will submit insurance claims on my behalf requesting that payment be made directly to them. If the commercial insurance carrier agrees to pay the physician directly, I will be required to pay any deductible (if not met) or any applicable co-insurance amounts.
3. I understand that I am financially responsible for any non-covered and / or denied charges incurred on my behalf.
4. I understand that for my office consultations with **ANH P. DANG-VU, MD, PC** without a proper referral for the date of service, I will be held financially responsible for the office visit.
5. I understand that if I do not provide the office with the proper insurance information at the time of service, I will be held financially responsible for the visit.
6. A copy of this agreement may be used in place of the original.

Please sign below to indicate that you have read and understood the information above.

Patient/Parents/ Guardian Signature

Date

WAIVER FOR PERMISSION TO REPORT LAB RESULTS

We would like to ensure that you are notified of your test results in a timely manner. To best accomplish that we ask that you complete the following question and we will do our best to accommodate them in our effort to assure smooth communication.

Would you prefer that we contact you with normal results? Yes _____ No _____

Phone number that you would like us to call with you results _____

Would you like us to leave the results on your answering machine? Yes _____ No _____

Is it OK to call you at work? Yes _____ No _____

Home telephone# _____ Work # _____ Cell # _____

Would you like us to leave a message with another person? Yes _____ No _____ If yes, with whom?

Patient/Parent/Guardian Signature

Date

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PATIENT MEDICAL HISTORY

This form is a part of your permanent medical record. Please complete it as thoroughly

Past Surgical History:

Family History of non-melanoma or melanoma skin cancers
