CYNTHIA B. YALOWITZ, M.D., F.A.A.D.
Adult and Pediatric Dermatology
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WWW.LARCHMONTDERM.COM 3 NORTH AVENUE, LARCHMONT, NY 10538 PHONE (914) 833-3030
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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 with the best dermatologic care.

- APPOINTMENTS – At least 24 hours notice must be provided if you cannot keep your appointment. If not, a $50 fee may be added to your account.

- INSURANCE – Please present your current insurance card each time you visit our office. It is your responsibility to confirm ahead of your appointment whether we participate in your specific plan. It is also your responsibility to obtain a referral if your plan requires one. Your signature below indicates your agreement that if your insurance company denies payment because of the absence of a referral, you will pay for an out-of-network visit.

- PAYMENT FOR CO-PAYS, CO-INSURANCE, DEDUCTIBLES, OUT-OF-NETWORK, AND NON-COVERED SERVICES –
  - Payment for co-pays, co-insurance and non-covered services is due at the time of service. Cash or check for copays under $25 are appreciated.
  - For covered services, you are responsible for any balance due, per your insurance company's explanation of benefits.
  - We encourage you to provide us with your credit card information for the purpose of settling any coinsurances, deductibles or copay differences to avoid balance billing. Your credit card information will be kept in a secure location and will only be used for balances on your account after the insurance company or companies have finalized the claim. To do so, please fill out the credit card information below.
  - In the event that we need to bill for co-pays, non-covered services, or other unpaid balances, after initial billing we may add a $15 administrative fee per billing cycle. If the account is turned over to a collection agency, the agency fee will be added to the account.

- LAB SERVICES – Your signature below authorizes laboratory services associated with your care and indicates your permission for the laboratory to bill your insurance company directly and to release any medical information needed to determine the benefits payable.

- CONSENT FOR TREATMENT OF A MINOR – I give permission for my child to be evaluated and treated in my absence. (if applicable)

- PRIVACY – We maintain patient confidentiality. Your signature below authorizes our office to release your information to other health care providers in connection with your care and to your insurance company to determine the benefits payable. A copy of the office's "Notice of Privacy Practices" is available on request.

I have read and agree to the above:

PATIENT'S NAME:_____DATE:_____

PATIENT OR GUARDIAN SIGNATURE:_____

_____

CREDIT CARD (VISA,MASTERCARD,DISCOVER ONLY)

CARD #: _____---_____---_____---_____

EXPIRATION DATE: _____ SECURITY CODE: _____

NAME ON CARD: _____