

New healthcare laws require ALL of the below *Patient Registration* information be completed. Thank you.

PATIENT REGISTRATION

Patient's Name (please print clearly) _____
(First) (Middle Initial) (Last)

Address _____ Zip Code _____
(Street) (City, State)

Home phone (_____) _____ Work phone (_____) _____ Cell phone (_____) _____

Pharmacy Name & Address _____

Sex: Male ___ Female ___ Date of Birth ___/___/___ Social Security No. of **Patient** _____ - _____ - _____

(Marital Status) Name of Primary Care Physician (If this applies) Referred by (Name of friend, or relative)

RACE (check one):

- White
- Black/African-American
- American Indian/Alaska Native
- Native Hawaiian/Other Pacific Islander
- Asian
- Other
- Patient Declined/Unknown

ETHNICITY (check one):

- Spanish/Hispanic Origin; or
- Not of Hispanic Origin
- Patient Declined/Unknown

LANGUAGES SPOKEN (please list):

Preferred language _____
Secondary language _____

If the Patient is a minor (less than 18 years old)

Name of Parent (or Guardian) _____ Address _____

Parent (or Guardian) Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

PRIVACY INFORMATION

1. Our office has instituted steps in order to comply with federal *HIPAA regulations* that protect patient health information and privacy. We have a written "**Notice of Privacy Practices**" available for your review.
2. When you return this form to the receptionist, **you will be asked to sign that you have been provided with this "Notice of Privacy Practices"**.
3. In order to confirm your **Appointments** and provide you with your **Medical Information**, we may try to contact you by: calling you at home, at work, or on your cell phone; leaving a message with another person; sending reminder cards or information by mail or email. **In the space below, please list any restrictions on the ways in which we may contact you regarding your Appointments or Medical Information.** (Leave blank if none.)

HIPAA contact *restrictions* and/or instructions: _____

FINANCIAL RESPONSIBILITIES OF PATIENT

1. I understand that I am financially responsible for all services rendered.
2. **At every office visit, I will present the Check-In receptionist my most recent insurance card that contains accurate and up-to-date insurance information – so that a can be made for my file.**
3. **Late Cancellation Fee:** I understand that your office requires at least **24 - 48 hours advance notice** for canceling or changing an appointment, and that if I fail to give the required notice, **then a late cancellation fee will be charged.** For **Monday appointments, I understand that I need to cancel or make changes by 12:00 Noon on Friday.**
4. I understand that if this office participates with my insurance, then this office will bill my insurance company. I understand that I am responsible for: the co-pay (at the time of the visit); the yearly deductible; any co-insurance; non-covered services; and cosmetic services. A late fee of 1½% per month will apply for accounts over 30 days late. You will not be balance billed for covered services.
5. I understand that if this office does not participate with my insurance, or if I do not have health insurance, then I am responsible for payment in full upon completion of the visit. As a courtesy, we may agree to bill your insurance company first, and await their payment, before billing you for any balance due. Generally, this exception is for expensive surgical procedures. Payments made by insurers we do not participate with, for less than the full amount billed, are not considered payment in full, and you would be responsible for the remaining balance.

It has been explained to me that Coastal Dermatology, P.C. (Dr. Daniella Duke) is NOT an authorized TRICARE Provider. I understand that I will be solely responsible for the bill, and that neither I nor Coastal Dermatology, P.C. will submit a claim for the services provided by Coastal Dermatology, P.C to TRICARE. Despite Coastal Dermatology, P.C.'s status as a Non-Authorized TRICARE Provider, I choose to receive medical care from them.

6. I understand that if I am covered under a gatekeeper or capitated plan, then I need to obtain a referral from the doctor my insurance plan designates as my primary care doctor (internists, family practitioners, and pediatricians) – and our office needs to obtain the referral **before my visit.** It is my responsibility to make sure this referral is current and complete. **If your insurance plan requires a referral, and you have not obtained one, you have several options:**
 - a. Call your primary care doctor and have them give you the required referral.
 - b. Reschedule today's appointment until you have obtained the referral.
 - c. Pay for the visit today, and submit the claim to your insurance company yourself.
7. I understand that if my secondary insurance doesn't apply (for example, if the secondary insurance requires a referral and one has not been obtained), then co-payments and/or annual deductibles are due upon completion of the visit.

I have read and understood the above policies and obligations, and agree to them for all office visits, including future ones:

You will sign this form electronically in the office

Signature of Patient (or Parent/Guardian)

ASSIGNMENT OF BENEFITS

For services rendered by Coastal Dermatology, P.C., I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical benefits, to: Coastal Dermatology, P.C., 55 Willow Street, Mystic, CT 06355. This includes Medicare, private insurances, and other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as an original. I hereby authorize Coastal Dermatology, P.C. to release all information necessary to secure payment.

You will sign this form electronically in the office

Signature of Patient (or Parent/Guardian)
