Manhasset Dermatology, P.C.
Patient Registration Form

Name: _____ ☐ Jr ☐ Sr
First *MI* *Last*

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **Gender:** ☐ Male ☐ Female **Date of Birth:** ____/____/_____

Race: _____ **(African American, Asian, Caucasian, Chinese, Hispanic, multiracial, etc.)**

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Social Security #: _____ **Preferred Language:** _____

Address: _____
Street # *Street Name* *Apt #*

_____
City *State* *Zip*

Home Phone: (___) _____ **Alternate/Cell Phone #:** (___) _____

Employer: _____ **Work Phone:** (___) _____
Name

Referred By: _____ **Primary Care Physician:** _____

Pharmacy Name: _____ **Pharmacy Telephone No.:** _____

Please tell us how you learned about our office: ☐Insurance ☐Friend ☐Family **Other:** _____

Spouse's Name: _____ **Spouse's Date of Birth:** ____/____/____
M D Y

If Student: ☐ Full Time ☐ Part Time **Name of School:** _____

I authorize Manhasset Dermatology, P.C. to release medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize my doctor to act as my agent in helping me obtain payments from my insurance company. I also authorize payment of medical benefits to the physician. Should my insurance carrier require a referral from my primary care physician, I must obtain such referral and present it at the time of my visit. Should I fail to obtain the required referral form by the end of the date of service and/or should my insurance fail to make a payment for my visit, I am assuming responsibility for payment of these charges and can be billed directly. In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. Should your check be returned for insufficient funds, an additional $40.00 fee will be added to your account. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services, or co-payments. Your signature below signifies your understanding and willingness to comply with this policy. I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Signature: _____ **Date:** _____

Do we have your permission to:

Leave a message on your answering machine at home?	☐ Yes	☐ No
Leave a message at your place of employment?	☐ Yes	☐ No
Discuss your medical condition with any member of your household?	☐ Yes	☐ No

If yes, with whom: _____ **Relationship:** _____

We must be able to confirm your appointment. Please indicate telephone number where we may speak to you, or leave a message to confirm your appointment.

Telephone number: (___)_____

01-2012

INSURANCE INFORMATION

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

Patient's ID #: _____ **Patient's ID #:** _____

Group #: _____ **Group #:** _____

Name of Policy Holder: _____ **Name of Policy Holder:** _____

Patient's Relationship to Policy Holder: _____ **Patient's Relationship to Policy Holder:** _____

POLICY HOLDER INFORMATION (IF DIFFERENT FROM PATIENT)

Name: _____ **Relationship:** _____

Address: _____ **Home Phone: ( )** _____

Social Security #: _____ **Date of Birth:** ____/____/____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

With my consent, Manhasset Dermatology, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Manhasset Dermatology, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Manhasset Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Manhasset Dermatology, P.C.'s O.C. Privacy Officer. With my consent, Manhasset Dermatology P.C. may call my home or other designated location and leave a message on voice mail of a person in reference to any items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Manhasset Dermatology P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Manhasset Dermatology P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Manhasset Dermatology P.C. may decline to provide treatment to me.

SIGNATURE ON FILE

I authorize Manhasset Dermatology, P.C., to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents. I authorize release of any information related to any claims to all my insurance companies or other relevant parties. I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. I authorize my doctor to act as my agent in helping me obtain payments from my insurance companies. I authorize payment of health benefits otherwise payable to me, directly to my doctor. I permit a copy of this authorization to be used in place of the original.

_____	_____	_____
PRINT NAME	**SIGNATURE**	**DATE**

PATIENT CONSENT FOR RELEASE OF MEDICAL REPORTS

I authorize Manhasset Dermatology, P.C. to release Laboratory reports, Pathology reports, and Consultation reports to Myself, Parent/Guardian, Referring and/or Primary Care Physician and/or Plastic Surgeons and other health care providers involved in my care.

_____	_____	_____
PRINT NAME	**SIGNATURE**	**DATE**