Patient Registration Date: _____

Patient Information (please complete using your name as listed on your insurance card)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Date of birth:** _____ **SS#** _____

Marital Status:_____ **Sex:**____ **Race:**_____ **Ethnicity:**_____ **Preferred Language:** _____

Occupation: _____ **Employer:** _____

Pharmacy Name: _____ **Street/ City:** _____ **Phone:** _____

Insurance Responsibility Are you the primary holder of the insurance policy? No_____ Yes_____ (if yes, skip this box. If no, please answer the following questions.)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Date of birth:** _____ **SS#** _____

Sex:_____ **Occupation:** _____ **Employer:** _____

Insurance Information All Patients must provide a copy of their insurance card at the time of their visits.

Primary Insurance: _____ Name of Insured: _____

Relationship to Insured: __Self __Spouse __Child

Secondary Insurance: _____ Name of Insured: _____

Relationship to Insured: __Self __Spouse __Child

How Did You Learn About Our Office? _____

Referring Physician: _____ **Phone #** _____

Primary Care: _____ **Phone #** _____

Emergency Contact Information

Name: _____ **Relationship:** _____ **Phone:** _____

Patient Release Must be signed by patient if over 18 or by legal guardian of patient under 18.

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

I certify that I hereby authorize Belaray Dermatology PC, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, or biopsy. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

Signature: _____ Today's Date: _____

Patient Acknowledgements Belaray Dermatology Office Policies

Insurance Information Co-Payments and Deductibles
Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances that are past due. Your signature below signifies your understanding and willingness to comply with this policy.

New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Signature:_____ Date:_____

Referral Information
If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; Belaray Dermatology will reschedule my appointment.

Signature:_____ Date:_____

Cancellation Policy
Should you be unable to keep your appointment, please contact our office at least 48 hours ahead of your visit. Failure to contact the office in a timely manner will result in a $25.00 fee. This fee is not reimbursable by your insurance company.

Signature:_____ Date:_____

May We Leave A Message With Test Results On Your Answering Machine: Yes No

If YES, What phone number may we leave messages at: _____

HIPAA Policy
Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Belaray Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I acknowledge a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 is available at any time both in the office, and at Belaray.com.

Signature:_____ Date:_____

Patient Name _____ Age_____ Date_____

Referring Physician:_____ Primary Care Physician: _____

Allergies:_____

Current Medications: _____

Reason for Today's Visit: _____

Current or Past Problems with: (Review of Systems)	Yes	No	(If Yes, Explain)
Asthma			
Diabetes			
General Health			
Eyes			
Ears/ Nose/Throat			
Heart (Pacemaker/ Defibrillator)			
Lungs			
Stomach/Bowel			
Kidneys			
Arthritis/ Muscles/Joints			
Skin			
Headaches/Seizures			
Psychological Disorder			
Thyroid			
Blood/Bleeding Disorder			
Allergic/ Immunologic			
Hepatitis			
HIV			
Other			
Females: Are You Pregnant?			

Check The Following Medical Conditions That Have Occurred In Your Family

Disease	Mother	Father	Blood Relative
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Hayfever			
Heart Disease			
High Blood Pressure			
Lung Disease			
Malignant Melanoma			
Psoriasis			
Skin Cancer			
Tuberculosis			

Surgical History: _____

_____

Social History: Do you....

Smoke? __Y __N Frequency____

Drink? __Y __N Frequency____

Recreational drugs? __Y __N Frequency____

Occupation:_____

Hobbies:_____

Physician Signature:_____ Date:_____

BELARAY DERMATOLOGY PC

Dear Patient

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payment, deductibles, and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides.
Your health care coverage, including your responsibility for co-payments, deductibles, and co-insurance, is a decision made by you or your employer, not this office or your health plans.

Our office will be pleased to work with your health benefit plan in verifying your eligibility, benefits, and requirements for prior authorization or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health care plan not honor the claim we submit for services provided to you.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but not limited to, Co-payments, deductibles, and/or uncovered services) in an amount not to exceed $300.00.
In these cases you will be notified that your credit card was charged.

Patient Name _____

Name on Credit Card_____
Card type (Visa) (MasterCard) (Amex) (Discover)

Card number:_____Exp. Date_____

Signature:_____ Date _____