FROMM DERMATOLOGY,PC

Provider _____

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.:	Email Address:

Address		City/State/Zip:
Mailing Address (if different):		
Home Phone:	Cell Phone:	Work Phone w/ext.:
Primary Care Physician (PCP):	Date of Birth:	Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner		
Soc. Sec. #:	Employer Name:	
Emergency Contact:	Phone:	Relationship to Patient:

Responsible Party

Person responsible for the bill (Only if patient is minor child):

Last: First: M.I.:

Date of Birth:	Soc. Sec. #:	Phone:
Address of Person Responsible:		City, State, Zip:
Employer of Person Responsible:		Relationship to Patient:

Insurance & Payment Info

MUST COMPLETE:

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name: ID: Group #:	Ins. Co. Name:
Policy Holder's Name:	Policy Holder's Name:
Effective Date:	Effective Date:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Policy's Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:
Employer Name:	Employer Name:

Additional Information

Can we leave a message regarding your medical care and test results? ☐ No ☐ Yes If yes: ☐ Brief or ☐ Extended * ☐ Home or ☐ Cell	How would you prefer to receive your appointment reminders? Voice Message ☐

Race (please select one): ☐ White ☐ Native American or Alaska Native ☐ Asian ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Hispanic ☐ Other ☐ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other _____

Preferred Pharmacy Name & Location:

Assignment of Benefits - Release of Information - Financial Responsibility

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Fromm Dermatology, PC (FDPC). I further authorize assignee to obtain my plan provisions under ERISA and to act as authorized representative on my behalf on insurance claims. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical record copies, necessary to secure payment and to complete disability forms presented to me. In response to any reasonable request for cooperation, I agree to cooperate with FDPC in any attempts by FDPC to pursue such claim, chose in action or right against my insurers and/or employee health care plan.

Certain physicians (e.g. pathologists and radiologists) may interpret your test results. These physicians are not employees or agents of **Fromm Dermatology, PC** and you may therefore receive a separate bill from these physicians for their services. You may also receive a separate charge on a subsequent day from the physicians for these services. The undersigned authorize these physicians to bill you and/or your insurance(s) for these services and receive any direct payment from any insurance benefit. A $40 plus tax service charge will be assessed against all non-sufficient funds/closed account checks. I have read and fully understand this agreement.

Patient_____ Parent/Guardian (if applicable) _____ Date_____ FDPC

Authorization for the Use and Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Fromm Dermatology PC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

I,__________________________________,hereby authorize and request the use and disclosure of all of the health information that pertains to me. I authorize and request Fromm Dermatology PC to make these disclosures of my health information. I authorize and request the following persons to receive these disclosures of my health information and elect not to provide statement of purpose for the use of the disclosure to the following persons (please print):

Name	Relationship	E-Mail Address	Phone #
Name	Relationship	E-Mail Address	Phone #
Name	Relationship	E-Mail Address	Phone #

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected. I understand that this authorization will automatically expire on December 31, 2018, but that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Fromm Dermatology PC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I have received a copy of Fromm Dermatology PC's Privacy Notice.

__________________________________ ______________________________

Signature of Patient or Parent of Minor Child Date

Minor Consent Form

Children under the age of 14 must be accompanied by an adult for any appointment.

As the Parent/Guardian to____________________________________, age_______, a minor, I am authorizing the following:

_______ I authorize______________________________, to be seen at any FDPC facility without a parent or guardian present.

Please Initial

_______ I authorize______________________________, a minor, to be seen and treated at the Fromm Dermatology, PC

Please Initial when accompanied only by the following adult, friend, child care provider, etc.

Name	Relationship
Name	Relationship

I further understand that this authorizes the Fromm Dermatology PC to provide medical and/or billing information to various laboratories, radiology or other medical facilities for tests that may become necessary for treatment. I accept responsibility for all physician charges, laboratory, radiology or any related fees. This authorization will remain in effect until revoked by me or the minor becomes 18 years of age.

__________________________________ ______________________________

Parent or Guardian Date

Only complete this section if you wish to revoke this authorization. **HIPAA or MINOR CONSENT**

__________________________________ ______________________________

Patient Name Patient's Date of Birth

__________________________________ ______________________________

Parent or Guardian Signature Today's Date