PATIENT DEMOGRAPHICS

Patient Legal Name_____ Preferred Name_____

Patient Date of Birth_____ Patient Social Security #_____-_____-_____

Mailing Address_____
Street Apt # City State Zip

Preferred Phone Number (_____)_____ Email address_____

Marital Status: Single Married Divorced Widowed Gender: Male Female

Emergency Contact_____
Name Address Phone #

(IF PATIENT IS A MINOR) RESPONSIBLE PARTY/PARENT HERE TODAY:

Name_____ Relation_____

Mailing Address_____
Street Apt # City State Zip

Social Security #_____-_____-_____ Preferred Phone Number (_____)_____

POLICY HOLDER INFORMATION (Please present insurance cards):

Primary Information:

Name_____ Birthdate_____ Relation_____

Address_____

ID#_____ Ins Co Name _____

Secondary Information:

Name_____ Birthdate_____ Relation_____

Address_____

ID#_____ Ins Co Name _____

WRITTEN ACKNOWLEDGEMENT

We have permission to leave messages concerning appointments, medical care, and/or test results on your answering machine or with a family member. **YES NO**

I authorize you to discuss my medical care, test results, and/or billing with the following individuals:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I hereby acknowledge receipt of Rocky Mountain Dermatology's Notice of Privacy Practices.

Patient/Parent Signature_____Date_____

Name_____ Patient ID#_____

Office Financial Policy

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. *As a courtesy to our patients, we will submit claims to your insurance carrier(s) if you provide us with* ALL CORRECT AND PERTINENT INFORMATION TO PROCESS A CLAIM AT THE TIME OF YOUR VISIT. **You are responsible for all annual deductibles, copayments and/or coinsurance. You are also responsible for all charges for non-covered and/or cosmetic services.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility. Credit on accounts will be extended for 60 days ONLY IF WE HAVE THE NECESSARY INFORMATION TO EXERCISE OUR THIRD-PARTY RIGHTS. IF YOU CANNOT PROVIDE THIS INFORMATION, YOUR ACCOUNT IS DUE AT THE TIME OF SERVICE unless other payment arrangements have been made. A DISCOUNT MAY BE GIVEN ON ACCOUNTS WITHOUT INSURANCE (*Self-Pay)* BUT REQUIRES PAYMENT IN FULL AT THE TIME OF SERVICE. In the event of default and referral to an attorney or collection agency, I agree to pay all collection costs including reasonable attorney fee.

Release of Information/Consent for Service

By receiving services you agree to release claims related information for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor.

On behalf of the patient, consent is hereby given to this facility, medical staff, and employees to provide necessary health care services. It is understood that there is some risk involved in any health care service such as scarring, recurrence, possible medication reactions, etc. Such risk is accepted in the hope of obtaining beneficial results from such services. No guarantee for assurance has been given to me by anyone as to results that may be obtained

Cosmetic Services

I understand that cosmetic services will not be covered by insurance and payment is expected at time of service.

Medicare/Medicaid/Tricare Patient Certification

I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries to carriers or to the state any information needed to process a claim for this or any other related services. I request that payment of authorized charges is made in my behalf directly to Rocky Mountain Dermatology for services provided to the patient.

Patient/Parent Signature_____**Date**_____

APPLIES TO SUBSEQUENT DATES OF SERVICE

My signature below signifies my understanding and willingness to comply with policies. I have also reviewed my Patient Information and certify that the address, phone number, insurance, HIPAA directives, and all other information is correct. I also certify that I have provided my current insurance card.

SIGNATURE	DATE	SIGNATURE	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____