PATIENT REGISTRATION

First & Last Name: **DOB:** **Sex at Birth:** F / M **Gender Identity:**

Patient Address: Apt# city state zip code

Primary Phone #: cell home (please circle one)

Agree to receive Appointment Reminder Texts yes no (please circle one)

Secondary Phone # cell home work (please circle one)

Email address:

Referring Doctor: **Phone #:**

Primary Care Physician: **Phone #**

Emergency Contact: **Phone #:** **Relationship:**

INSURANCE SUBSCRIBER INFORMATION

Primary Insurance Name: **Specialist Copay:**

Policy Holder Name: **Policy Holder DOB:**

Policy Holder Address:

Phone # **Relationship:**

Secondary Insurance:

Policy Holder: **DOB:**

I have been given the opportunity to review Dermatology Associates of Morris, P.A. HIPAA Notice of Privacy Policy which can be found on dermatologyassociatesofmorris.com or in our offices. I verify the accuracy of the above information.

_____ _____

Print Name of person signing form **Signature (patient must sign if over age 18)**

_____ _____

Date **Relationship to patient (self, guardian, parent, P.O.A.)**

As per NJ state law, you have the right to request a chaperone during your examination. Please advise the doctor if you would like a chaperone present during your exam.

AUTHORIZATION & RELEASE OF PROTECTED HEALTH INFORMATION

Dermatology Associates requires all patients to complete this form to indicate patient authorization to use and/or disclose certain protected health information (PHI) to the party or parties listed below in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law.

I authorize all Dermatology Associates of Morris, P.A. staff to disclose all protected health information, unless I note restrictions, to the party/parties listed below until the specified expiration date. I have the right to revoke this authorization which must be in writing.

Print Name_____

_____

Phone Number Relationship Expiration Date

Print Name_____

_____

Phone Number Relationship Expiration Date

Print Name_____

_____

Phone Number Relationship Expiration Date

By signing this form, you authorize the Practice to disclose Protected Health information. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect ay disclosures we have already made in reliance on your prior authorization.

_____ _____ _____

Print Patient Name **Signature** **Date**

OFFICE POLICIES OF DERMATOLOGY ASSOCIATES OF MORRIS, P.A.

At Dermatology Associates of Morris, we are committed to providing you with the highest quality medical care. We feel it is important for our patients to review and sign our Office Policies prior to their visit.

INSURANCE

We require an active insurance card at every visit. You will need to present this card when you check in for your appointment. If you arrive without your insurance card, we may need to reschedule the appointment. It is your responsibility to inform the office of any changes in your insurance.

REFERRALS

Dermatology Associates of Morris is considered a specialist. Many health insurance plans require referrals for specialist services. It is the patient's responsibility to ensure that he/she has a valid referral for each appointment. Without this referral in place, we will need to reschedule the appointment.

FINANCIAL

Dermatology Associates of Morris is a specialty practice. Your insurance company determines the customary and reasonable fee for services provided. Patient balances may be due to charges applied to your deductible, a co-insurance (cost sharing percentage), your copayment, any fee that is considered cosmetic and not medically necessary, or balances determined to be patient responsibility by your insurance company. It is our policy to collect your copayment, fees for procedures that are considered cosmetic, and past due balances at the time of service. Copayments and fees for services can be paid by cash, check or credit cards.

The patient will receive a statement in the mail for all outstanding balances. Any outstanding balance is due within 30 days of billing. If the payment has not been received, your account may be referred to our collection agency and a collection fee of $33^{1/3\%}$ will be added to the unpaid balance upon placing your account in collections.

Any skin tissue removed during your appointment will be sent to a pathology lab. You will receive a separate bill from the lab. You are to contact the lab with any questions regarding the lab bill.

For injectable cosmetic services, we require these be paid in full at the time of service by credit card or cash only.

CANCELLATIONS

If you need to cancel or change an appointment, we ask that you contact our office at least 24 hours prior. Patients who do not show for their scheduled appointment will be charged a $25.00 fee for a regular appointment and $50.00 fee for a missed surgical or patch testing appointment.

LATE ARRIVALS

It is our goal to do our best to keep to the schedule of appointments. When a patient arrives late, it is difficult for the physicians to keep on schedule. If you do arrive late, it may be necessary to reschedule your appointment.

_____	_____	_____
Print Patient Name	**Signature**	**Date**