RODGERS
DERMATOLOGY

PATIENT REGISTRATION

2017

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIALS	NAME YOU PREFER TO GO BY

MAILING ADDRESS	DATE OF BIRTH	SEX ☐ FEMALE ☐ MALE

CITY	STATE	ZIP	SOCIAL SECURITY #	PHONE #

EMAIL ADDRESS:	WOULD YOU LIKE TO BE NOTIFIED OF SPECIALS OR EVENTS BY EMAIL? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US? ☐ GOOGLE ☐ PHYSICIAN ☐ WORD OF MOUTH ☐ INSURANCE ☐ WORD OF MOUTH ☐ OTHER

WHAT IS THE REASON FOR TODAY'S VISIT?

IF PATIENT IS UNDER AGE OF 18

PARENT/ GUARDIAN NAME	CONTACT NUMBER

ADDITIONAL CONTACT INFORMATION

ADDITIONAL AUTHORIZED CONTACT (FULL NAME & RELATIONSHIP)	CONTACT NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME _____	INSURANCE NAME _____
POLICY/ ID# _____	POLICY/ ID# _____
GROUP/ ACCOUNT# _____	GROUP/ ACCOUNT# _____
CARDHOLDERS NAME _____	CARDHOLDERS NAME _____
DOB _____ _____	DOB _____ _____
RELATION TO PATIENT _ _____	RELATION TO PATIENT _ _____

PHYSICIAN INFORMATION

NAME OF REFERRING PHYSICIAN		CONTACT NUMBER
PRIMARY CARE PHYSICIAN		**CONTACT NUMBER**
OTHER PHYSICIAN	**SPECIALITY**	**CONTACT NUMBER**
OTHER PHYSICIAN	**SPECIALITY**	**CONTACT NUMBER**
OTHER PHYSICIAN	**SPECIALITY**	**CONTACT NUMBER**

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PHARMACY INFORMATION

PHARMACY NAME	PHARMACY CITY	PHARMACY CROSS STREETS

ALLERGIES (PLEASE LIST ALL MEDICAL ALLERGIES)

☐ **NKDA (NO KNOWN DRUG ALLERGIES)**

1.	**2.**
3.	**4.**

MEDICATIONS

PLEASE LIST ANY MEDICATIONS

1.	**2.**	**3.**	**4.**
5.	**6.**	**7.**	**8.**
9.	**10.**	**11.**	**12.**

DO YOU SMOKE ANY TOBACCO PRODUCTS AT ALL, EVEN OCCASIONALLY?	☐ YES ☐ NO
ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC	RACE ☐ CAUCASIAN ☐ AFRICAN ☐ AMERICAN INDIAN ☐ ASIAN ☐ OTHER

HAVE YOU EVER HAD SKIN CANCER?

☐ BCC	☐ SCC	☐ MELANOMA	☐ YES, UNSURE WHICH TYPE

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS

1.	**2.**	**3.**	**4.**
5.	**6.**	**7.**	**8.**
9.	**10.**	**11.**	**12.**

I hereby authorize and consent Rodgers Dermatology, Dr. Rodgers, his staff and others as appropriate to:

1. Evaluate and treat my medical conditions, or evaluate, examine and treat my dependent(s) as applicable.
2. Call me at home or work with regard to appointment reminders, lab results, or information about my care.
3. Leave a message on my answering machine or voice mail with appointment reminders or lab results.
4. Send information to me in the mail regarding appointments, patient education, or information.
5. Release my medical records to my referring or primary physician, and to my insurance company, if applicable.
6. At my request or in emergency, discuss my medical condition with another member of my household or family.

Yes ☐ **No** ☐ **If yes, whom?**

_____

SIGNATURE: _____ **DATE** _____

RODGERS DERMATOLOGY
The Skin Doctors

PATIENT REGISTRATION

Treatment Consent

I hereby authorize and consent to treatment at Rodgers Dermatology (RD). This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment.

Authorization & Assignment

I authorize Rodgers Dermatology and/or my physician to furnish information to my insurance carriers concerning my diagnosis and treatment. If I do not make payment in full for such services, I assign to Rodgers Dermatology all payments for services rendered to my dependents or me.

Medicare Claims

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Payment Guarantee

*** Patient Responsibility**. I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether covered by an HMO, PPO, or a traditional group health plan.

If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If your account is placed with a collection agency, we will terminate the availability of our services to you and you will be dismissed from the practice.

*** Contracted Insurers**. If we participate (are contracted) with your insurance plan, we file claims as a courtesy to you. You will be responsible for:

- Co-payments
- Annual deductibles
- Coinsurances
- Non-covered services

*** Non-Covered Services.** Insurers routinely state, "The determination of coverage is made at the time the claim is submitted." We often don't know if treatments will be covered until we receive the insurer's EOB (explanation of benefits). After the EOB for your submitted claim has been received at RD, you will be billed for any items not covered by your insurance plan. Services may be denied for coverage because the carrier considers the services: 1.) medically unnecessary 2.) pre-existing condition 3.) cosmetic

I feel that these services are necessary. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment.

*** Transfer of Credit Balance**. A credit balance resulting from payment to RD from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

*** Pathology & Laboratory Charges**. Final laboratory charges cannot be anticipated at the time of service and are not within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. You will be responsible for any amount not covered by insurance.

Fees

*** Co-Pay Rebilling Charge**. Our contract with your insurer requires us to collect any co-payments in full at the time of service. If for any reason the correct co-pay is not collected at the time of service, a $10 service charge will apply for additional billing to collect the correct co-pay.

*** Insurance Rebilling Charge**. If your insurance claim requires a second submission because of incorrect insurance policy information, there will be an additional $15 charge. This charge will be the patient's responsibility. If the correct insurance information is not obtained before your insurer's claim filing deadline, you will become responsible for the full cost of the visit.

*** Rebilling Charges**. After the first 30 days, any outstanding charges will be subjected to an additional $5 charge each billing period for mailing and handling fees.

*** Returned Checks**. A $25 processing fee will be charged for returned checks. Returned checks may also be forwarded to our collection agency for further action.

*** Transfer of Records.** Under the Texas Administrative Code governing medical records release and charges, a physician shall provide medical or billing records if requested. A physician shall be entitled to receive a reasonable, cost-based fee for providing the requested information. A reasonable fee shall be a charge of no more than $25 for the first twenty pages and $.50 per page for every copy thereafter. If an affidavit is requested, certifying that the information is a true and correct copy of the records, a reasonable fee of up to $15 may be charged for executing the affidavit. A physician may charge separate fees for medical and billing records requested. The fee may not include costs associated with searching for and retrieving the requested information.

*** Appointment Cancellation or 'No Show'.**

As a courtesy, our office has an automated appointment reminder system that calls 2 days before to verify your appointment. This provides adequate time to cancel or change your appointment if needed. 24 hour notice is required to avoid the $25 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

Medication Refills

Patients are given enough medication to sustain them until their next visit. A follow up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given.

No Insurance Card

If you arrive without your insurance card for your first visit, you will be charged our standard commercial fee. We are not able to provide an insurance discount or contracted fee without that card and supporting identification. No refunds or insurance discounts will be provided after the fact.

A copy of this authorization shall be valid as the original.

Signature/Patient or legal representative **Date**