DERMATOLOGY PHYSICIANS GROUP

Patient Registration Form 7/18

Please be aware that it is your responsibility to obtain and confirm a referral prior to each visit if required to do so by your health insurance plan.

Patient Name: _____Date of birth: _____

Email: _____ Marital Status:_____ Sex: M / F / MTF / FTM

Language preference: _____ Race: _____ Ethnicity: _____

Address: _____Unit: _____

City:_____ State:_____ Zip:_____

Home phone: _____ Cell: _____

Occupation: _____ Work Number: _____

Employer (Address/Phone):_____

Policy Holder: _____ DOB: _____

Emergency contact (Name): _____ Relationship: _____

Emergency contact (Telephone): _____

Primary Doctor: _____ Phone #: _____

Address: _____ Fax #: _____

Pharmacy: _____ Phone #: _____

Address: _____

_____ _____
(Please Print Name of Patient, Parent/Guardian) (Date)

_____ _____
(Signature of Patient, Parent/Guardian) (Date)

Office Policies and Practices 6/18

Scheduling Policy

Our physicians and staff recognize that your time is valuable and strive to maintain a schedule that runs on time. In order to assist our office in this goal, we suggest that new patients arrive 10 minutes early to your appointment in order to complete registration forms and paperwork. Patients arriving 15 minutes or more past their scheduled appointment time may be required to reschedule in order for other patients to be seen on time. When scheduling your appointment, we recommend that you give yourself an hour, between check-in, time with the doctor, and check-out, in order to not feel rushed.

If you are unable to attend a scheduled appointment, you are required to call and cancel the appointment at least 24 hours in advance. Failure to notify the office within 24 hours will result in the assessment of a $25 fee for a missed office visit and/or $50 for a missed surgical appointment.

Financial Policy

All co-payments are to be paid at check-in on the day of the appointment regardless of insurance coverage. All cosmetic procedures are to be paid prior to the time of service.

Non-insured, out of network, and patients without a referral (if required by insurer) must pay in full at the time of service.

When a parent or guardian accompanies a minor/dependent, the parent/guardian is the responsible party on the account and is financially responsible for all charges incurred in the medical treatment of the child/dependent whether or not paid by insurance.

I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to remit payment within 3 weeks of receipt of a statement from Dermatology Physicians Group, LLC (DPG). **In order to avoid late payment or collections fees, DPG requires that you keep a credit card on file with our office** to pay any balance due after insurance has paid its portion of your bill. We will send you an invoice and wait 30 days for payment. If no payment is received 30 days after the invoice date we will charge your credit card for the balance due.

I am aware DPG reserves the right to send past due balances to collections that may affect my credit. Accounts sent to collections will have a $25 service fee added to the original past due balance. I authorize the use of my signature on all insurance submissions. Dermatology Physicians Group may use my (or my child/dependent's) health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Notification of Privacy and Nondiscrimination Practices

DPG is compliant with current Health Insurance Portability and Accountability Act (HIPAA) privacy practices and Affordable Care Act (ACA) nondiscrimination practices. Our detailed HIPAA privacy practices and ACA nondiscrimination practices are available for you to review while in the office, on our website at www.dpgchicago.com, and a paper copy of these policies is available upon request.

My signature below acknowledges that I have reviewed, understand, and agree to the above policies and practices of Dermatology Physicians Group, LLC.

_____

(Please Print Name of Patient, Parent/Guardian)

_____ _____

(Signature of Patient, Parent/Guardian) (Date)

DERMATOLOGY PHYSICIANS GROUP

Patient Contact Consent for Protected Health Information (HIPAA)

Doctor to Patient Communication

In order to provide the best quality of care, our doctors and medical staff will need to be able to reach you to discuss issues pertinent to your care: e.g., pathology results, laboratory test results, prescription refills.

Authorized Telephone Numbers

Preferred #: _____ May we leave a message? ❑Yes ❑No

Alternate #: _____ May we leave a message? ❑Yes ❑No

Alternate #: _____ May we leave a message? ❑Yes ❑No

Family to Doctor Communication

At times, a spouse, parent, child, or significant other may wish to contact our doctors or staff with questions regarding your care, prescriptions, test results, emergencies, etc. If you authorize us to discuss your care with another individual, you must list them on this form.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name (printed): _____

Patient Signature: _____ Date: _____