Dermatology Specialists of Boulder, PC (DSB)

REGISTRATION SHEET

Last name ___________________________
First name_____________________MI___
(As printed on Insurance card if applicable)

PCP (Doctor's Name) __________________________
Telephone # of PCP__________________________
Referring Provider____________________________

Preferred name__________________

Date of birth_________________________________
Sex: Male or Female

Address line 1__________________________
Address line 2__________________________
City_________________________________
State ___________ Zip____________
Home phone________________________
Cell phone___________________________
Work phone__________________________

Email address______________________

Marital status: S/ M/ / Partner
Social Security #________________________________
Employer name______________________________

How did you hear about us?____________________

Emergency contact__________________________
Phone #: __________________________________
Relationship to Patient:______________________

Primary Insured Responsible Party (Fill out this portion if different from Self)

Name: Self / Other Named ________________________________MI: ______ DOB________________
Address:________________________________City_______________State___________Zip____________
Telephone #:__________________________________Relationship to Pt____________________________

Fill out this portion if card cannot be scanned. Insurance Company Name _________________________
Subscriber # ______________________________ Group #:______________________________

INSURED RESPONSIBILITY: It is understood that services rendered by DSB are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of DSB to collect from the insurance company. We do this as a service to our patients.

PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to promptly pay the balance in full.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All returned checks (NSF, Account Closed, Refer to Maker, or Uncollected Funds) are subject to a $40 service charge and cost of collection fee. In consideration of any services rendered by DSB, or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for DSB to employ anyone, including attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to DSB.

Do we have your permission to:

1) Leave a detailed message on your answering machine at home? _____ Yes _____ No
2) Discuss your medical condition with any member of your family? If yes whom? __________________ Relationship:____________
Whom? ___________________Relationship_____________

In signing this document, I am attesting that I have read the above and that I have had all of my questions answered to my satisfaction.

___________________________________ ____________
PATIENT SIGNATURE/LEGAL GUARDIAN DATE