

Dermatology Specialists of Boulder, PC (DSB)

REGISTRATION SHEET – PLEASE COMPLETE

Last name _____ Primary Care Physician _____
First name _____ MI _____ Telephone # of PCP _____
(As printed on Insurance card if applicable) Referring Provider _____

Preferred name _____ Date of birth _____
Sex: Male or Female
Address line 1 _____ Marital status: S/ M/ / Partner
Address line 2 _____ Social Security # _____
City _____ Employer name _____
State _____ Zip _____ Race/Ethnicity _____
Home phone _____ Preferred Language _____
Cell phone _____ How did you hear about us? _____
Work phone _____ Emergency contact _____
Phone #: _____
Email address _____ Relationship to Patient: _____
(for DSB purposes only)

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 collection agencies and 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