DERMATOLOGY REGISTRATION FORM

PATIENT INFORMATION:

LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ CELL: (____) _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: _____ SOCIAL SECURITY NO: _____

E-MAIL ADDRESS: _____

EMPLOYER'S NAME/ADDRESS: _____

_____

SPOUSE'S OR PARENT'S NAME : _____

INSURED NAME: _____

INSURED RELATIONSHIP: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP:_____TELEPHONE:_____

PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN:_____

PLEASE NAME WHO IS RESPONSIBLE FOR AUTHORIZING TREATMENT AND WHO WILL BE RESPONSIBLE FOR THE BILLING

NAME: _____ RELATIONSHIP: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE: (____) _____ WORK PHONE (____) _____ CELL: (____) _____

ALL MEDICARE CLAIMS ARE FILED BY THIS OFFICE, AS WELL AS MEDICARE SUPPLEMENTAL AND VARIOUS PPO/PAR PLANS. IF WE DO NOT FILE YOUR INSURANCE, YOU WILL BE FURNISHED WITH A RECEIPT THAT YOU CAN USE TO FILE.

CHECK ALL APPLICABLE: _____MEDICARE _____PRIVATE _____NONE

PLEASE PRESENT ALL INSURANCE CARDS TO BE COPIED SO THAT THEY CAN BE KEPT IN YOUR PERMANENT FILE.

Financial Responsibility Agreement

I HEREBY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES AND WILL PAY FOR THESE CHARGES AT THE TIME THE SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Michael Braden, MD, PA retains the right to add 35% to your balance owed if your account becomes delinquent and is turned over to a collection agency.

METHOD OF PAYMENT: _____Cash _____Check _____Visa/Mastercard

_____

Signature Date

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Michael Braden, M.D., P.A. to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to Michael Braden, M.D, P.A. all benefits if any. If payment is made to me by my insurance company I will promptly turn payment over to Michael Braden, M.D., P.A. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Michael Braden, M.D., P.A. will be credited to my account, in accordance with this assignment.

_____

Signature Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made to Michael Braden, M.D., P.A. for any health care services provided to me. I authorize any and all health care professional(s) and/or facility(s) to release any of my medical information needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and it's agents. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "OTHER HEALTH INSURANCE" is indicated in the ITEM 9 box of the HCFA-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. If Medicare assignment applies, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Signature Date

PATIENT MUST SIGN THE APPROPRIATE SECTIONS BEFORE SEEING THE PHYSICIAN.