

Centre Dermatology & Aesthetic Medicine

Patient Registration

Male Female

Patient Name

Date of Birth

Street Address

City, State ZIP Code

Home Phone

Cell Phone

Emergency Contact

Relationship Phone

Please provide us with your email if you want to hear about upcoming promotions: _____

Office Policies

Insurance Filing Authorization

I certify that the information contained in my registration and health history forms is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Centre Dermatology & Aesthetic Medicine. I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependant, whether or not they are covered by my insurance. I also authorize Centre Dermatology & Aesthetic Medicine to release any information required to process my claims.

HIPPA Notice of Privacy Practices

I have read a copy of Centre Dermatology & Aesthetic Medicine's *Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize the release of any medical information necessary to evaluate or treat my condition. I further authorize the release of any medical information necessary to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the *Notice of Privacy Practices*.

Payment Policy

Payment is due at the time of service. This includes any outstanding co-pay or insurance deductibles. I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependant, whether or not they are covered by my insurance. If my insurance requires a referral and this is not on file at the time of my appointment, I understand I am responsible for payment at the time of my visit.

Cancellation Policy

We require a 24 hour cancellation notice. Centre Dermatology & Aesthetic Medicine reserves the right to charge the patient a minimum fee of \$25.00 if we are not given sufficient notice. Additionally, Centre Dermatology & Aesthetic Medicine reserves the right to reschedule appointments to which the patient is more than 20 minutes late.

I have read and received the Centre Dermatology Acknowledgement of office policies and agree to the terms and conditions.

Parent /Guardian Signature

Date

By signing below, I hereby authorize my insurance benefits (if applicable) to be paid directly to Lynn A. Baden, M.D., P.C. I realize that I am responsible for payment of non-covered services, co-payments, and deductibles. I also authorize the release of pertinent information to my insurance carrier.

Patient / Guardian Signature

Date