

Email completed forms to:

[results@columbiadermatology.com](mailto:results@columbiadermatology.com)

Use "last name\_firstname\_DOB" in the subject line of your email

**OR**

Complete the forms and bring them to your office visit

**PATIENT REGISTRATION FORM**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
First Middle Last MM / DD / YYYY

SEX:  MALE  FEMALE  OTHER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

SELECT PREFERRED CONTACT:  \_\_\_\_\_  \_\_\_\_\_  
Home # Cell #

EMERGENCY CONTACT: \_\_\_\_\_  
Name Relationship to patient Phone #

**Do we have your permission to:**

Leave a message on your voicemail?  Yes  No  
 Discuss your medical condition with any member of your household?  Yes  No

EMPLOYMENT: \_\_\_\_\_  
Occupation Employer name / Company Phone #

PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
Physician / Practice name Phone #

**PHARMACY OF CHOICE:** \_\_\_\_\_  
Pharmacy name Address or Location Phone #

**PRESENT YOUR INSURANCE CARD(S) FOR PHOTOCOPY AND COMPLETE BELOW**

If no card is available, payment in full is expected

**PRIMARY INSURANCE COMPANY**

**Ins Company** \_\_\_\_\_

Are you the policyholder?  Y  N. IF NO, complete below:

Policyholder Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**PRIMARY INSURANCE COMPANY**

**Ins Company** \_\_\_\_\_

Are you the policyholder?  Y  N. IF NO, complete below:

Policyholder Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**PAYMENT AND INSURANCE AGREEMENT**

I attest the above information is correct and will be used for billing purposes. I authorize release of medical information to my insurance company (s), primary care or referring physician and pharmacies. Further, your signature authorizes the Doctor to release medical information necessary to process your insurance claims (if any). If my insurance company does not pay, I understand that I am responsible for my bill. I understand that I am responsible for my bill. **Charges, deductibles, copays, and/or coinsurances are due at the time of service. A charge of \$25.00 may be assessed for a missed appointment. Also, if we are forced to turn your account over to our collection agency, you will be responsible for all collection fees incurred. I understand that I am responsible for obtaining a referral from my primary care doctor if required by my insurance. If I fail to obtain the referral, I will be responsible for my bill.** I authorize Columbia Dermatology Center to act as my agent in helping me obtain payment from my insurance company (s). I authorized payment directly to Columbia Dermatology Center. A copy of this can be used in place of the original.

**You will be given the opportunity to review our Notice of Privacy Practices. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996. Please initial to confirm this opportunity.**

The above is true and correct to the best of my belief.

\_\_\_\_\_  
 Patient / Responsible Party Signature

Date \_\_\_\_\_  
 MM / DD / YYYY



Name (print): \_\_\_\_\_

## Financial Policy

We are pleased that you have selected our office to provide your Dermatologic care. As part of that care, we have developed this statement of our financial policy. Please carefully read the following, initial where indicated, and sign below.

### Health Insurance Participation

Initials Columbia Dermatology participates in many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you may reschedule your appointment or payment for your visit will be due today.

### Co-payments

Initials Some insurance plans require payment of a Co-pay. Co-payments are due at check-in. Payments can be made by check, cash, MasterCard or VISA. Without a co-payment, you may be rescheduled.

### Referrals

Initials Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral, your appointment may be rescheduled or payment for your visit will be due today.

### Financial Responsibility

Initials Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.

### Account Balances

Initials All outstanding balances must be paid at time of check-in, or you must reschedule your appointment. Failure to pay outstanding balances may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%.

### Rescheduling/Canceling Appointments

Initials Please help us serve you by keeping your scheduled appointments. Should you need to change your appointment, contact our office at least 24 hours prior to your originally scheduled visit. Following two consecutively missed appointments, a \$25 missed appointment fee will be charged. After three consecutively missed appointments, the scheduling of future appointments would be at the discretion of your physician.

*If you are more than twenty (20) minutes late for your appointment, you will be asked to reschedule your appointment.*

I have read and understand the office policies explained above.

\_\_\_\_\_  
Patient / Responsible Party Signature

Date \_\_\_\_\_  
MM / DD / YYYY