PATIENT INFORMATION

NAME: _____ DOB: _____ GENDER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

EMAIL ADDRESS: _____

EMPLOYER & ADDRESS: _____

NAME/ADDRESS OF OTHER PHYSICIAN: _____

IF MINOR:

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

WHY DID YOU SELECT OUR OFFICE? _____

EMERGENCY CONTACT: _____ RELATION: _____

PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____

ADDRESS: _____

SUBSCRIBER: SELF / OTHER: _____ DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ ID #: _____

ADDRESS: _____

SUBSCRIBER: SELF / OTHER: _____ DOB: _____ RELATIONSHIP: _____

OFFICE POLICY INFORMATION

Signing below indicates acceptance and awareness of the following terms:

Release of Medical Information Authorization / Assignment of Insurance Benefits / HIPAA Privacy Provisions Notification

I authorize Saybrook Dermatology, LLC to release any medical or other information necessary to process my insurance claims. I also assign my insurance benefits to be paid directly to Saybrook Dermatology, LLC according to the terms of my insurance policy.

Saybrook Dermatology, LLC maintains a copy of the Notice of Privacy Practices mandated by the Health Insurance Portability and Accountability Act of 1996 posted in its waiting rooms for review. I am aware that a summary of this Notice is available upon my request to take and review at my leisure.

Financial Responsibilities

I will be responsible for any copayments required by my insurer at the time services are provided. I understand a $50 charge will be incurred for missed appointments or cancelled appointments without 24 hour notice.

I will be responsible for any coinsurance and/or deductibles payable to Saybrook Dermatology, LLC as required by the terms of my insurance policy. I understand payment plans are available upon request.

If my insurance requires me to obtain a referral prior to receiving services, I will do so or be liable for any insurance claims denied for not notifying my insurer.

I will be responsible for reporting to Saybrook Dermatology, LLC any contact information or insurance coverage changes.

Signed: _____ Date: _____