Dermassociates, Ltd ▪ Gary J. Vicik, M.D.

Patient Registration Form

Name____ Goes By:_________________
Last First M.I.

Mailing Address____

____
City State Zip

E-mail address: ____

Primary Phone (____) _______________Cell Phone (____) __________________Work Phone (____) _______________

Date of Birth _____/____/_____ SS#_______________________ Marital Status__________ Sex______

Employer_________________________________ Full time ____ Part time ____ Retired ____ Student ____

Spouse's Name: ____

Person to notify in case of emergency (Please list a person not living in your home)
___________________________________ Relationship _________ Phone number _________________

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Primary Insurance Name ______________________________ Patient's Relationship to Policy Holder________________

Policy Holder (if different from patient) ____________________________ Policy Holder's Date of Birth: ____/____/____

Address of Policy Holder: ____

Phone (_____)____-_______ Insurance ID # ____________________________________

Secondary Insurance Name ___________________________ Patient's Relationship to Policy Holder________________

Policy Holder (if different from patient) ____________________________ Policy Holder's Date of Birth: ____/____/____

Address of Policy Holder: ____

Phone (_____)____-_______ Insurance ID # ____________________________________

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If a patient is a minor: Person Responsible for Bill (Parent- Step-Parents, Guardians, etc)

Name____DOB:____________ SS# ______________________

Mailing Address____
Street City State Zip

Home Phone (____)______________ Cell(____)___________________ Work Phone (____)______________

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. I understand insurance eligibility does not guarantee payment. I agree to abide by the rules of my insurance, PPO or HMO plan; and pay my co-insurance, co-pay or deductible amount.

Signature ____ Date ___________________________

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Patient Financial Policy

This office has contracts with Medicare and many other health insurance plans. Please check with our reception staff to determine whether your plan is one of these.

You are excepted to present your insurance card at each visit. If we have a contract with your plan, we will file a claim with your insurance company. **All co-pays, deductibles, coinsurance percentages or fees for non-covered services are required at time of service. Any past due balances are also due and payable at the time of service.**

If your insurance is an HMO and requires a referral from your primary care physician (PCP), **you are required to have prior authorization from your PCP prior to your office visit.** If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Payment is required at the time of service for all **SELF-PAY ACCOUNTS.** Self-pay accounts include: patients without an insurance card on file; patient who are covered by insurance companies with which Dermassociates does not participate; or patient who have not met their deductible.

There could be a charge for broken or missed appointments without a 24 hour notice to cancel or reschedule.

If at any time you are concerned about the cost of the procedure proposed by the provider, you may ask someone from the billing office who will be happy to discuss the cost with you.

- Please note that even if a procedure is medically necessary and "covered" by a given insurance, **there may be deductibles or coinsurance amounts that are your responsibility and required at the time of service.** Any surgeries, including, but not limited to: Excisions, Biopsies, Removals, Liquid Nitrogen, and Wart treatments all fall under the surgery codes per the American Medical Association. Please notify you provider if you would like to be given the price and codes for your treatment before having them performed. We can give you the information for you to contact your insurance company to verify coverage and how your claim will be paid.

It is your responsibility to know the coverage and requirements of your health plan regarding office visits, diagnostic testing, physicians referrals and other preventative services.

There will be a charge for the following: -Copies of medical records for any non-physician recipient & Returned checks

For your convenience, this office accepts Master Card, Visa, and Discover, in addition to cash and checks. **All balances must be paid in full when billed.**

For Cosmetic or Self Pay procedures: 50% is due when the procedure is scheduled and the balance is due at the time of service. Cancellations made within 3 business days of scheduled-service are subject to forfeiture of the deposit.

If you do not pay your account balance in full, when due, you may be sent to the credit bureau for collection. All collection fees and court costs will be added to your balance due.

It is our hope that the above financial policy will serve as a notification to you, our patient, of your responsibilities in order for us to provide you're the best quality care. If you have questions or need clarification of any of the above policies, please do not hesitate to contact our billing office at 618-397-6605.

I certify that I have read the financial policy of Dermassociates, LTD, and agree to abide by the policy.

Signature _____ Date _____

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Acknowledgment of Receipt of Notice of Privacy Policies (HIPAA)

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, we ask that you please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice. I have been given the option of signing a separate Patient Consent Form.

Signature ____ Date_____________________

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Due to Federal Privacy Regulations we cannot leave message with protected health information on the home answering machines or with family members without written persmission.

With my consent Dermassociates may call my home or other designated location and leave a message or voicemail or in person in reference to any item that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, billing questions, insurance items and any call pertaining to my clinical are, including laboratory results among others.

With my consent, Dermassociates, Ltd. may mail to my home or other designated location that assist the practice in carrying out TPO, such as appointment reminders.

____ I **DO NOT** want any medical or billing information released except personally to myself at this phone number

______________________.

Signature ____ Date ______________

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May we leave a message on your home answering machine or cell phone? _________________

May we leave a message for you at work to call us? _________________

May we discuss your medical condition with another person? ______________

If yes, whom ____ Relationship_____________________

____ Relationship_____________________

____ Relationship_____________________

Signature: _______________________________________ Date: __________________________