

PATIENT REGISTRATION Appointment with: Dr. Robert N. DeAngelis Dr. Carol N. Currey Chart #: _____

Patient Last Name: _____

First Name: _____ MI: _____

Previous Name/Nick Name: _____
(Maiden name, former married name, etc.)

Patient Date of Birth: _____ Male Female

Mailing Address: _____

Patient SSN: _____ - _____ - _____

City: _____ State: _____ Zip Code: _____

Marital Status: Single Married Divorced Widowed

Home Phone: _____ Cell Phone: _____

Legally Separated Partner

Student Status: Full-Time Part-Time Not a student

Responsible Party/Primary Insurance Holder (If not patient above)

Employment Status: Employed Unemployed Self Employed Retired

E-mail Address: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ - _____ - _____ Date of Birth ____/____/____

Home Phone: _____ Cell Phone: _____

Male Female Relationship to patient: _____

Responsible Party Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Emergency Contact (if different from Responsible Party)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____

Relationship to patient: _____

INSURANCE INFORMATION: If the patient is not the primary policyholder, the Responsible Party section above must be completed.

Self Pay (No insurance or Out-Of-Network) Patient **IS** the policy holder Patient **IS NOT** the policy holder

Primary Insurance Co.: _____ Policy Number _____ Group Number _____

Secondary Ins. Co.: _____ Policy Number _____ Group Number _____

Patients who are Minors: If the patient is younger than 18, then a parent or legal guardian must sign documents. A parent or legal guardian must be present for any patient under age 16.

If under age 18, check if parent or guardian is present:

Yes, Parent/guardian Present No, Parent/guardian is not present

Release of Medical Information

By signing below, I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Privacy Practices (HIPAA) By signing this document, I acknowledge I have read and understand Dr. DeAngelis' and Dr. Currey's Notice of Privacy Practices.

Authorize release to: _____

Did a doctor refer you to us for a specific problem? Yes No
Problem _____

REFERRING PHYSICIAN/PA/NURSE/MEDICAL PROVIDER INFO:

Dr: _____

Address: _____

City/State: _____

YOUR PRIMARY CARE PHYSICIAN:

Dr: _____

WERE YOU REFERRED BY ONE OF OUR PATIENTS? PROVIDE INFO:

Name: _____

Address: _____

By signing below I attest that all of the information provided above is true and accurate. I agree and understand that the terms herein are reaffirmed each time services are received by me and any person on my account receiving treatment.

Responsible Party/Primary Insurance Holder (Must have signature of Responsible party)

_____/_____/_____
Date

Financial Agreement-Chart #

Your signature below confirms that you have read, understand and agree to the information in this agreement and all insurance information is accurate and current:

This is a **Financial Agreement** between Dr Robert N. De Angelis or Dr Carol Currey and the responsible party signing this form. Your signature implies that you have read this Agreement and agree to all the terms and conditions contained herein and the Agreement will be in full force and effect. Additionally, you understand and agree that payment for services is your legal obligation as the patient or guarantor (responsible party) for the patient or persons on your account and agree to pay any charges not covered by your insurance company.

If the doctor/s do not participate with your insurance company and you still elect to see them, you will be responsible for payment in full on the day services are provided. We participate with a number of health plans. However, this can change periodically; therefore, it is imperative that the patient inquire with their insurance company prior to any services and before scheduling an appointment. It is the patient's responsibility to know and understand their plan benefits. If your insurance information changes, it is your responsibility to inform our staff so they can update information to properly process your claims. If claims are rejected due to untimely filing, based on outdated computer information in our files, you could lose your valuable insurance benefits and be responsible for all services provided by the doctor. Promptly inform our staff of any changes. Please be aware that as medical providers, our relationship is with you and not your insurance company. Problems with your coverage should be handled between you and your carrier.

Insurance Information-Out of Network/Non-Participating/Cosmetic Procedures/Self Pay:

All filing of insurance claims that are considered Out of Network, Non-Participating, Cosmetic, or Self Pay for Dr Robert De Angelis and Dr Carol Currey and confirmation of eligibility of benefits and/or confirmation of insurance services/payments is your responsibility. If, as a courtesy we file your insurance claim after receiving full payment from you on the day of your office visit, we will reimburse any payment received back to us by the insurance company. Cosmetic procedures are considered Self Pay and are paid in full at the time of the office visit. Some procedures require a pre-payment deposit. If you have any questions as to what dermatological procedures might be considered cosmetic, please ask the staff. Your signature on this agreement affirms your understanding that payment/fees for all services considered to be Out of Network, Non-participating, Cosmetic, and Self Pay is your responsibility. You hereby agree to pay to the provider all fees due for services rendered and/or expenses incurred by you, your spouse, any of your children or dependents or members of your household who are on your account.

In-Network/Participating Insurance Filing/Insurance Identification and Co Pay:

All confirmation of eligibility of benefits and/or confirmation of insurance services/payments to be made by your insurance company is your responsibility. If the doctor is a contracted or a participating provider with your health insurance plan and we are filing your claim for you, you must present a current insurance benefit card showing personal identification, current eligibility information for the patient, and a photo identification card of the insurance guarantor, to be copied for our records. If you do not have those documents you will have to reschedule your appointment. In all cases, where the doctors are contracted and participate with a patient's healthcare plan, a co-payment is required prior to your being seen by the doctor. Most insurance companies also require the plan member to pay a deductible & co-insurance that is specific to each plan and is your responsibility. Once the insurance company receives your claim and processes it, based on your coverage, you and our office will receive an EOB (Explanation of Benefits) detailing services covered, including any co-insurance, deductible or uncovered services that will be due immediately to the doctor.

All efforts will be made to avoid sending the account to our collection attorney. Once a patient's account is delinquent, a delinquent fee of \$25.00 will be added for each delinquent patient in the account. If your account is sent to our collection attorney, the undersigned agrees to pay attorney fees of 33.33% of the unpaid principal and interest that is or becomes due, plus all court costs and interest of 18% per annum, beginning 30 days after the monies have become due or expenses have been incurred. In the event a payment plan is in place and the account is in arrears, interest at the above rate will begin on the last payment date, and the account balance will become due immediately, including the above costs of collection, including court costs and attorney fees. The undersigned agrees to pay a returned check fee of \$35.00 per check.

I, the undersigned, agree that the payment of my bill is my legal obligation as the patient. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmations. I understand and agree that the terms herein are reaffirmed each time services are received. I also agree that the above terms are reaffirmed each time services are received by any person on my account receiving treatment.

Signature: _____ Date: ____/____/____

Printed Name: _____