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PATIENT REGISTRATION FORM

Patient Name: DOB: Age: MRN#:

Sex: Marital Status: SS#:

Phone: Cell: Work:

Address:

Responsible Party Name: DOB: SS#

Pharmacy: Pharmacy Phone:

Pharmacy Address: City: State: Zip:

REFERRING DR: PRIMARY CARE DR:

Phone: Fax: Phone: Fax:

Address: Address:

PRIMARY INSURANCE: SECONDARY INSURANCE:

Policy #: Policy #:

Group #: Group #:

Policyholder: Policyholder:

Relationship to Policyholder: Relationship to Policyholder:

Primary Ins Effective Date: Secondary Ins Effective Date:

Policyholder Date of Birth: Policyholder Date of Birth:

Specialist Copay:

EMERGENCY CONTACT: Phone #:

I, the undersigned, irrevocably assign Rivergate Dermatology, PLLC all insurance payments made payable to me or on my behalf, including but not limited to, surgical, medical, liability or other for all charges for services rendered to me. I irrevocably instruct my attorney(s), if any, to honor this Assignment. I am responsible for all charges from Rivergate Dermatology, PLLC, whether paid or unpaid by insurance. I hereby authorize Rivergate Dermatology, PLLC, to release all necessary information to secure payment by insurance(s).

Signature:____ Date:__________________Relationship to Patient:_________________________

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and other listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications.

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time, I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

______ (Patient/Guarantor initials) **I consent to receive text messages and emails from the practice.** I consent to receive texting at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ feedback/ health information unless I request a change in writing.

- The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is ____. ***The practice does not charge for this service, but the standard text messaging rates may apply as provided by your wireless plan (contact your carrier for pricing plans and details).***
- The email that I provide to receive email messages for appointment reminders and general health reminders/ feedback/ information is ____.

Consent for Photographing or Other Recording for Security and/or Health Care Operations.

______ (Patient/Guarantor initials) I **consent** to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership of the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without specific written authorization from me or my legal representative unless it is for treatment, payment, or health care operations purposes or otherwise permitted or required by law.

______ (Patient/Guarantor initials) I **do not consent** to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Patient/Guarantor Signature: ____ Date: ________________________

Patient Name (Printed): ______________________________ DOB: ____________________