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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 have reviewed and agree the above information is correct to the best of my knowledge.

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.

_____ (Patient/Guarantor initials) I consent to receive text messages and emails from the practice.

- The cell phone number that I authorize to receive text messages 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 is _____.

Acknowledgement of Notice of Privacy Practices

With my consent, Rivergate Dermatology, PLLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Upon request, I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent. Rivergate Dermatology, PLLC reserves the right to revise its Notice of Privacy Practices at any time.

Financial Policy

Rivergate Dermatology, PLLC participates in a variety of insurance plans. Should there be any questions or problems with your claim, please contact your insurance carrier. You, the patient, is responsible for providing the correct insurance information. All copays, coinsurance and deductibles are due at the time of service. A statement of any unpaid fees is sent out regularly and due upon receipt. It is your responsibility to be sure that your account is paid. Any questions regarding our financial policy should be directed to our billing department.

I understand I am responsible for all charges from Rivergate Dermatology, PLLC whether paid or unpaid by insurance. I authorize the release of all necessary information to secure payment by insurance.

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

Patient/Guarantor Signature: _____ **Date:** _____

Patient Name (Printed): _____ **DOB:** _____