RIVERGATE DERMATOLOGY & SKIN CARE CENTER

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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.

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

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