

Patient Registration Form

Name: _____ Jr. Sr.
First Middle Last

Address: _____
Street # Street Name Apt #

City State Zip

Employer: _____
Name Address Phone

Home Phone: _____ Date of Birth: ____/____/____ Age: ____
Month Day Year

Work Phone: _____ Cell Phone: _____

Last Four Digits of Social Security Number: _____ Sex: M F

Primary Care/Family Physician _____
Address Phone No.

Does your insurance require a referral? Yes No e-mail address _____

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE. HMO PATIENTS MUST HAVE A VALID REFERRAL IN ORDER TO BE SEEN. IF YOU DO NOT HAVE A REFERRAL YOUR APPOINTMENT CAN BE RESCHEDULED OR YOU CAN PAY FOR THE SERVICES THAT ARE RENDERED AT THE TIME OF THE VISIT. If you have no insurance or an insurance in which we do not participate you are responsible to pay for services in full at the time of the visit. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Your signature authorizes the Doctors to release such medical information necessary to process your insurance claims (if any). You authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Name of policy owner if other than patient: _____

Name: _____
Last First M.I.

Address: _____
City State Zip

Home Phone _____ Work Phone _____ SS: _____
Area Code Area Code

Date of Birth: ____/____/____ Sex _____

Please present insurance cards to the receptionist so copies may be made.

OVER

Dermatology Associates of South Jersey, LLC

112 White Horse pike
Haddon Heights, NJ 08035
856-546-5353, fax:856-546-8711

Patient Name

Date of Birth

To all Dermatology Associates of South Jersey, LLC patients,

In an effort to provide you with the best possible care and avoid any billing errors, we are asking our patients to please verify that our practice/doctors participate(s) with your insurance carrier. Most insurances have changed in the last year, and their coverage of certain procedures and treatments has also been impacted.

It is the patient's responsibility to provide us with a valid and up to date insurance card for every office visit. Our staff is required to ask for a valid ID and insurance card every time you are seen. If we are not provided with the correct insurance information at the time of the office visit, and your claim is denied, the bill will be passed on to you (the patient).

MEDICARE PATIENTS: If you are enrolled in a Medicare plan and DO NOT have a secondary insurance you will be responsible for the 20% that Medicare does not pay.

By signing this form, you are acknowledging and certifying that you have provided us with the most up to date and valid insurance information. If you have Medicare insurance you will be responsible to the 20% that it is not payed by your insurance. Also, if the incorrect insurance information is given, you (the patient) will be responsible for the amount owed for the office visit.

Thank you for your cooperation,

Dermatology Associates of South Jersey, LLC

Patient/Guardian Signature

Date
