Account #: ____________

Medicare Patient Registration for Aesthetic Dermatology & Cosmetic Surgery [1/17]

Name ____ Jr ☐ Sr ☐
First Middle Last

Date of Birth: ______/______/______ E-mail: ______________________________

You may communicate with me via my email: Yes________ No________

Prefer to be called ________________________ Title: Mr. ☐ Mrs. ☐ Ms. ☐ Miss: ☐

Address ____
House# Street Name Apt#

____
City State Zip

Home Phone______________________ Cell Phone__________________ Work Phone____________________

Social Security #___________________________ Medicare #___________________________________

Emergency Contact: ____ Phone #: ______________________

Pharmacy Name and Phone #: ____

Employer Name & Address____

I was referred to the Doctor by:___________________ ❑Google ❑Yelp ❑yp.com ❑Insurance ❑Friend ❑SocialMedia

I give permission to leave NORMAL results on voice mail/ to person answering the phone. Patient initial: ______________

YES	NO	
☐	☐	Have you recently joined a Medicare HMO? If yes: ________________________________
☐	☐	Do you or your spouse work in a company with more than 20 employees and you have coverage through the insurance at that job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness covered by the Veteran's Administration?
☐	☐	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness due to an auto accident or injury at work? If yes, explain.
☐	☐	Are you receiving Medi-Cal?

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

If you are covered by the above described insurances, **YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS, DEDUCTIBLE, AND FOR SERVICES YOUR INSURANCE DOES NOT COVER. IF THE INSURANCE YOU HAVE PROVIDED IS INVALID, OR IF YOU ARE IN AN HMO WE ARE NOT A MEMBER OF, YOU ARE RESPONSIBLE FOR PAYMENT IN FULL.** It is your responsibility, as the patient, to know and understand the benefits and limitations/exclusions of your insurance coverage. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any medical information necessary to process my medical claim and to obtain reimbursement. I have read this form and I understand and agree to its terms. I further agree that a photocopy of this agreement shall be as valid as the original.

PLEASE NOTE: For any pathology slides sent to UCSF Dermatopathology for further diagnostic and consultative services, you will be billed separately by that facility.

Completion of Forms/Photocopying of Medical Records: I agree to pay a service charge of $24.00 per hour, and .25 per page plus postage for Photocopying of my Medical Records or completing my insurance inquiry/ disability forms, and to pay before the service is rendered.

If you are experiencing financial hardship, please ask to speak with our office manager regarding a payment plan.

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. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ________________________________ Date ____/____/____

Copy of insurance card (both sides) attached. Updated By: ________________________