DERMATOLOGY CENTER OF DALLAS

8230 Walnut Hill Lane, Professional Bldg. III, Suite 500, Dallas, TX 75231 214-739-5821 / Fax – 214-739-0713

Peter D. Hino, M.D. Era Caterina Murzaku, M.D. J. B. Foshee, M.D.

PATIENT REGISTRATION ACCT#_____

PATIENT INFORMATION

Last Name: _____First Name: _____ MI:_____

Street Address: _____Apt #:_____City: _____State:____ Zip _____

Home Phone: ( ) _____ - _____ Alternate Phone#: ( ) _____ - _____ □ work □ mobile

Date of Birth: _____/_____/_____ Age: _____ Sex:_____ Email:_____

Employer: _____ Driver's License # _____Spouse Name:_____

Referring Physician: _____ Phone: _____

HEALTH INSURANCE INFORMATION

Insurance Company: _____ ID#_____

Group#____ _____ Relationship to Patient: _____ Ins. Co. Phone # _____

Insured Name: _____ Date of Birth: ____/____/____ SSN#: _____

PLEASE COMPLETE IF PATIENT IS A CHILD (UNDER 18 YEARS OLD)

Give information for the PARENT/LEGAL GUARDIAN who is accompanying child to this visit

Name: _____ Relationship to Patient: _____

Address: _____City: _____State: _____ Zip: _____

Home Phone #: ( ) _____ - _____ Alternate Phone #: ( ) _____ - _____ □ work □ mobile

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FINANCIAL RESPONSIBILITY: *I have read and understood the financial policy on the back of this registration* and agree that I am ultimately responsible for the balance of my account for any professional services rendered regardless of insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dermatology Center of Dallas to release any information acquired in the course of my examination or treatment to the insurance carriers involved in the payment of my account. I authorize fax transmittal as needed.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dermatology Center of Dallas.

SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

Payment in full is expected at the time of your visit unless prior arrangements have been made with our office. Your payment may be made to **'Dermatology Center of Dallas'** by personal check, cash or major credit card. If we have a contract with your insurance company and your insurance approves your visit, you will be responsible for the co-pay, deductible and co-insurance on the date of your service. We request that you are prepared for this at each visit and do not ask to be billed.

We file all medical and surgical care performed at **Dermatology Center of Dallas** to your insurance company. It is necessary that you provide us with accurate insurance information, a signed assignment of benefits and authorization to release information to your carrier(s).

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers and renewal date are constantly changing. In order for us to file your claims to the appropriate plan, we must have the most recent card presented. If you arrive without your card, you will be responsible for all charges until the billing office has received complete current and accurate insurance information. Most plans require that we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we received payment from the insurance plan.

Our filing of the insurance claim does not relieve the patient of his/her financial liability for the account. Forty-five days should be allowed for payment of a claim by the insurance company after it has been filed. PLEASE CONTACT YOUR INSURANCE COMPANY IF YOU HAVE QUESTIONS REGARDING THE CLAIM.

In the event that your insurance carrier refuses to make payments against your claim for services rendered by Dallas **Dermatology Center of Dallas**, for any reason, you agree to accept responsibility for prompt payment.

In the event of overpayment, a refund will be promptly made to the person responsible for the payment of the bill.

Patients who do not carry insurance or patients seen by **Dermatology Center of Dallas** for a **cosmetic procedure are expected to pay in full at the time services are rendered. A deposit may also be required for specific cosmetic procedures at time of scheduling.**

Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. **Dermatology Center of Dallas** will not get involved in matters involving third party personal billing whether result of custody, court order or personal circumstances. The parent/guardian accompanying the child to the visit is responsible for any payment due at the time services are rendered.

RETURNED CHECKS: A service charge of $25.00 will be charged to your account for any returned checks. You will be required to pay cash or credit card to cover the amount of the check plus the service charge.

MISSED APPOINTMENTS: A 24-hour notice is required for all cancellations or a $50.00 charge may be assessed to your account.

Thank you for taking time to read and understand our policies. Please let us know if you have any questions.

PLEASE SIGN THE FRONT OF THIS FORM AS CONFIRMATION THAT YOU HAVE READ AND WILL ABIDE BY THE ABOVE POLICIES AND RESPONSIBILITIES.