Debbie Miller Dermatology - Patient Registration

Personal Information*:*

First Name: _____ MI: _____ **Last Name**: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ **Gender:** _____ **Marital Status**: _____

Cell Phone (_____) _____ **Home Phone** (_____) _____

Can we leave you a detailed message? YES _____ NO _____

EMAIL: _____

Occupation: _____ Place of Employment: _____

How did you hear about us?

Doctor Referral _____ Family _____ Friend _____ Phone Book _____ Other _____

Responsible party if different from patient:

Name: _____ Relationship to Patient: _____

Address: _____ Phone Number (____) _____

In the event of an emergency please contact:

Name: _____ Relationship to Patient: _____ Phone (_____) _____

Insurance Information:

Primary Insurance: _____ **Policy Holder's Name**:_____

Policy Holder's DOB: _____ Patients Relationship to Insured: _____

Secondary Insurance: _____ **Policy Holder's Name**:_____

Policy Holder's DOB: _____ Patients Relationship to Insured: _____

Release of Medical Information:

I authorize Debbie Miller Dermatology to disclose my protected health information, including but not limited to appointment times, account detail, office notes, diagnostic tests, lab results, to the below-named persons. This authorization shall be in effect until I revoke it in writing.

Release Individual #1 _____ Release Individual #2 _____

Relationship to Patient _____ Relationship to Patient _____

Patient/Guardian Signature _____ Date: _____

Please Initial:

_____ When Dr. Miller biopsies or removes a lesion, your specimen will be sent out to a pathology laboratory for diagnosis. You will receive a separate bill from that outside pathology office for reading and processing the specimen. **This charge will be in addition to our charges**.

_____ I understand that medical procedures performed in the office (biopsies, cryotherapy, excision, C&D, etc.) are billed separately from the office visit.

Notice Regarding Insurance Claims/Payments:

I am responsible, regardless of insurance coverage, for payment on all rendered services. I am responsible for copayments, deductible amounts, coinsurance, non-covered services, or services deemed "non-medically necessary" by my insurance carrier. I understand co-payments are due at the time of services. I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest may accrue on all amounts 30 days or until paid in full. If any unpaid balances are referred to a third-party collection agency, I am responsible for all collection fees, as allowed by Oregon state collection laws, in addition to any other amounts such as interest, court costs, and attorney's fees. I agree, in order to service my account or collect any amounts I may owe, that Debbie Miller Dermatology may contact me by any telephone, email, or mailing address associated with my account**. A 24-hour cancellation notice is needed to avoid a $25.00 "NO SHOW" charge.**
By signing below, I acknowledge that I have read the Financial Policy above and agree to abide by its guideline**.**

Patient/Guardian Signature: _____ Date: _____