Cdermatology
Comprehensive Skin Care for Coloradans

# PATIENT REGISTRATION INFORMATION

Englewood, CO 80113
601 E Hampden Ave, Suite 350

Name: _____ Sex: _____M _____F
First Last MI

Date of Birth:_____ Age:_____ Social Security (SSN) #: _____ Language_____

Home Address: _____City_____State_____Zip_____

Cell:(___)_____ Work: (____)_____ Best contact #: _____

Employer's Address_____ _____ City_____ State_____ Zip_____

Occupation: _____ Marital Status: __single ___married __divorced __widowed

Is it OK to leave a message on your answering machine at work regarding pathology/ laboratory reports? Yes / No

What is your pharmacy's phone number? _____ Ethnicity_____ Race_____

E mail Address:_____ Can we contact you via e mail (appt reminders, office news)? Yes / No

Pt's medical doctor (internist/family doctor)_____How did you hear about us?_____

Do you want to participate in Social Media (Facebook, Twitter, etc) on the latest promotions/developments of our office? Y/N

## SPOUSE (OR PARENT/GUARDIAN) INFORMATION

Name: _____ Date of Birth_____ SSN#_____

Employer:_____Work Phone (___)_____

Employer's Address_____City_____State_____Zip_____

Person to Contact in Emergency_____Phone # _____

## PAYMENT INFORMATION

**Primary Insurance:**: _____Address:_____

Policy Holder's Name: _____ ID #: _____Group #_____

**Secondary Insurance**: _____ Address: _____ID#:_____

Relation to patient: _____ Group #: _____

## PAYMENT POLICY AND AGREEMENT

We expect payment of any deductible, co-payment, or cosmetic procedure at your visit. If your insurance plan is responsible for payment, **please present card to our reception desk**. Although we participate with many insurance companies and bill them for you, we are not responsible for your insurance coverage. Should your insurance deny payment **FOR ANY REASON,** you will accept responsibility for payment in full for any service rendered by the doctor on your behalf. Please be aware that we will bill your insurance as a courtesy and expect full payment upon your receipt of a statement. If you use a credit or debit card to make a payment, your card information will be stored. After two statements have been sent, we will charge the card information on file for the remaining balance. We have a **returned check charge** of $25.00 per check for any check returned unpaid by your bank for any reason. For **cancelled appointments,** we require **24 hours** notice; otherwise a $25.00 charge will be made. A "Collection fee" of $30.00 will be added to unpaid balances that are referred to an outside collection agency. **IF YOU HAVE A DEDUCTIBLE, PARTIAL PAYMENT IS DUE AT TIME OF SERVICE. IF YOU HAVE MET YOUR DEDUCTIBLE, PROOF THAT DEDUCTIBLE HAS BEEN MET WILL NEED TO BE PRESENTED.**

**PLEASE SIGN TO ACKNOWLEDGE THAT YOU HAVE READ & ACCEPT PAYMENT POLICY AGGREEMENT:**

Signed_____ Date _____