Stephen 0. Kovacs, MD PC Dermatology and Skin Surgery Centers

77 Warren Street, Suite 353 - Brighton, MA 02135 - Telephone 617-787-0400

61 Lincoln Street, Suite 307 - Framingham, MA 01702 - Telephone 508-820-0700

FAX 617-500-0976

PATIENT REGISTRATION AND INFORMATION

Last Name			First Name	MI	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐
Date of Birth	Age	Male ☐	Female ☐	Social Security #	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐
Street Address		City	State	Zip Code	Cell Phone Day/Office phone
Email Address					
Patient's Occupation		Employer			Employer Phone
Spouse's Last Name		First	MI		Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐
Spouse's Occupation		Employer			Employer Phone
Driver's License #		State	Have your other family members been seen by Dr. Kovacs?		

PRIMARY CARE PHYSICIAN

Last Name	First	Specialty Office Phone

REFERRING PHYSICIAN

Please complete if Referring Physician is not your Primary Care Physician

Last Name	First	Office Phone

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone	Work Phone

PHARMACY

Pharmacy Name	Location	Phone Number Fax Number

PLEASE LIST ANY MEDICATION ALLERGIES

INSURANCE INFORMATION

Please present your insurance card(s) with your registration form. We will copy all the information necessary for benefit reimbursement purposes.

Co-payments are due at time of service. Please note, with some insurances, Dr. Kovacs may be considered a specialty referral and your co-payment may be higher than reflected on you insurance card. Please check with your insurer if you have any questions. We greatly appreciate the opportunity to serve you. Thank you for your patronage.

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Patient's Certification and Authorization for Insurance Reimbursement and Agreement for Payment

The attached information is true to the best of my knowledge. I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payments directly to Dr. Stephen O. Kovacs, PC for medical services rendered to myself and/or my dependents regardless of insurance benefits, if any. I also authorize Dr. Stephen O. Kovacs, PC or the insurance company to release any information required to process my claims or secure payment for treatment. I have requested medical services from Dr. Stephen O. Kovacs, PC on behalf of myself and/or dependents and understand by making such request that I become fully financially responsible for any and all charges incurred for the course of treatment authorized. I understand that fees (copayments, deductibles, balances as determined by your insurance) are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that I am financially responsible for any balance. I further understand that it is my responsibility to secure referrals and all necessary authorizations under the guidelines of my insurance policy. I acknowledge that I will be financially responsible for all charges incurred should I not follow the terms and provisions of my health insurance policy. In the event of default, I understand that Dr. Stephen O. Kovacs, PC may use an outside collection agency and/or report any returned checks to the Attorney General's Office for the Commonwealth of Massachusetts. Not only will a photocopy of this assignment be considered as valid as the original but will also be valid for the period of lifetime unless revoked by me in writing.

Patient/Legal Guardian/Authorized Person (Signature) **X**	**Date of Signature** **X**
Patient/Legal Guardian/Authorized Person (Please Print Name)	**Relationship If Other Than Patient**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

I acknowledge that I have received and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities and that all my questions have been answered to my satisfaction. Also, I consent to the use or disclosure of my protected health information by Dr. Stephen O. Kovacs, PC, and all of its departments, operations, and locations for the purpose of diagnosing or providing treatment, obtaining payment for my healthcare services, or to conduct its healthcare operations that specifically include all satellite locations, billing and administration, laboratory and diagnostic center.

X_____ **X** _____

Patient/Legal Guardian/Authorized Person (Signature) **Date of Signature**

_____ _____

Patient/Legal Guardian/Authorized Person (Printed Name) **Relationship if other than Patient**

AUTHORIZATION ALLOWING DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE FOLLOWING INDIVIDUALS LISTED BELOW

In compliance with HIPAA's Privacy Rule, it is the policy of Dr. Stephen O. Kovacs; PC to allow properly authorized individuals to have access to your protected health information (PHI). This authorization will remain in force until revoked in writing by the patient. Please list below the individuals you wish to have access to your protected health information.

1 _____ _____

Name **Relationship**

2 _____ _____

Name **Relationship**

X_____ **X** _____

Patient/Legal Guardian/Authorized Person (Signature) **Date of Signature**

_____ _____

Patient/Legal Guardian/Authorized Person (Printed Name) **Relationship if other than Patient**