PATIENT REGISTRATION FORM

PATIENT NAME (Please use legal name as it appears on your insurance card) :

Name: ____ Birthdate: _____ /_____/______
LAST FIRST MIDDLE

Street Address:

City: State: Zip:

☐ Male ☐ Female

Home Phone: Cell Phone: Work Phone:

Email Address: ______________________________ Marital Status: Single - Married - Divorced - Widowed

RESPONSIBLE PARTY IF OTHER THAN PATIENT. **PRESENT ACCOMPANYING** PARENT/GUARDIAN IF PATIENT IS A MINOR:

Name: ____ Date of Birth: _________________
LAST FIRST MIDDLE Relationship:

EMERGENCY CONTACT

NAME: __________________________________ Phone Number: _________________________

PRIMARY INSURANCE INFORMATION Please bring your insurance card(s) with you.

Primary Insurance Company:

SECONDARY INSURANCE INFORMATION We will bill secondary insurance as a courtesy to you.

Secondary Insurance Company:

Primary Physician: ____________________________ Phone Number: ____________________________

Referring Physician: ____________________________ Phone Number: ____________________________

Co-pays & Deductibles: It is the responsibility of the patient to know their copay and their deductible. Your insurance plan is a contract between you and your insurance provider. It is your responsibility to know if your deductible has been met at the time of service. Procedures performed in our office are often classified as surgical codes and may be subject to your deductible. If you have not yet met your deductible, then you may receive a bill for services or treatments provided to you. __________ Please Initial

Assignment, Release & Financial Agreement: I authorize services of the person named above and agree to pay all fees for such services. I authorize my insurance benefits to be paid directly to the provider of service and I understand that I am financially responsible for non-covered services, co-pays and deductibles. I authorize the release of any information as required for payment. I understand balances over 60 days old may incur billing fees and I am responsible for any billing fees. There is a $50 fee for each NSF check returned to us by your bank, per RCW 62A.2-515&520. In the event it should become necessary to place any unpaid balance due with a collection agency, I agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper. ____________ Please Initial

Affiliation Disclosure Notice: Pursuant to RCW 19.68.010 this statement serves to disclose that Kyle J. Garton MD as part owner has a financial interest in Dermatopathology Northwest, a Dermatopathology laboratory that processes and interprets skin biopsy specimens. Skin biopsy specimens obtained at The Dermatology Clinic are routinely sent to Dermatopathology Northwest. However, upon request, a skin biopsy may be sent to an alternative laboratory, such as University of Washington Labs. Requesting a skin biopsy specimen be sent to another facility will in no way affect your treatment at The Dermatology Clinic. ____________ Please Initial

Phone Messages: I authorize The Dermatology Clinic to leave messages at my home or alternate number, for administrative purposes such as appointment reminders. ____________ Please Initial

Please sign below that information completed is true to the best of your knowledge. We are required by law to maintain the privacy of, and provide patients with, a notice of our legal duties and privacy practices with respect to protected health information. A signature below acknowledges that you have been given the opportunity to review and/or to receive a copy of our Notice of Privacy Practices.

Signature: ____ **Date:** ____________________