Visage Dermatology and Aesthetic Center, LLC

PATIENT REGISTRATION **WELCOME TO OUR PRACTICE!**

Please complete all blocks and print information. All information provided is permitted under HIPAA Privacy Act. Please note, providing your Social Security Number is permitted under HIPAA.

Last Name____ First_____________________________ M.I.__________

DOB________________________ SSN___________________________ Sex_________

Ethnicity (please check): ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

☐ Black or African American ☐ White ☐ Hispanic ☐ Unreported/Refuse to Report ☐ Other________________

Preferred Language______________________ Need Interpreter? ☐ Yes ☐ No (type, if yes)________________

Address____ City/ST/Zip_________________________________

Home #_________________________ Cellular #__________________________ Work #_____________________

Employer______________________________________ Occupation_____________________________________

***Email Address____
We use e-mail to communicate practice closings, educational events, and special offers. Providing your e-mail address also allows the patient care providers to contact you directly after hours or if they are unable to reach you by phone.

Primary Care Physician's Name _______________________________ Tel. _____________________________

Pharmacy Name, Location, Tel.____

Yes, I would like to receive text messages about our practice. These automated text messages will allow me to request an appointment and can include information about new services or team members, and special promotions as well as. I understand that I will always have the ability to opt-out if I decide that I no longer want to receive texts from this practice.

Initial ___________ Date _________

EMERGENCY CONTACT

Name___________________________________ Relationship_______________Contact #____________________

Guarantor/Parent DOB_____________________ SSN___________________________ Sex________________

Address (if different)_____________________________________ City/ST/Zip______________________________

Please give your insurance card(s) and photo ID to the front desk staff so we may copy/scan. Please complete the information in this section in its entirety.

PRIMARY INSURANCE CO ______________________________ GROUP # _____________ ID # ___________________

Effective Date __________ Co-Pay _________ Referral Yes/NO

Deductible____________ Satisfied Yes/No Deductible Remaining Amount __________

Are injections covered(Codes: **1190**, 11901 J Code: J3301)? XTRAC Laser (96920, 96921, 96922)?
Other Procedures: 11100(Biopsy), 17000(Benign Destruction),17003(benign destruction 2-14), 17004(>15),17110(warts 1-14), 17111(Warts >15),11300(shaving trunk), 11310 (shaving face),

Spoke With (Verified by) Date_______________ Time ___________

INS CO ADDRESS ____ PHONE # _______________

POLICY HOLDER'S NAME __________________________ Birthdate_______________

POLICY HOLDER's SOCIAL SECURITY NUMBER: ___________________________

RELATIONSHIP TO PATIENT ___ SELF ___ PARENT ___ SPOUSE ___________ OTHER

POLICY HOLDER'S EMPLOYER ____________________________________ EMPLOYER'S PHONE # _______________

EMPLOYER'S ADDRESS____

SECONDARY INSURANCE CO ____________________________ GROUP # _____________ ID # ___________________

INS CO ADDRESS ____ PHONE # _______________

POLICY HOLDER'S NAME __________________________ Birthdate____

POLICY HOLDER's SOCIAL SECURITY NUMBER: ___________________________

RELATIONSHIP TO PATIENT ___ SELF ___ PARENT ___ SPOUSE ___________ OTHER

POLICY HOLDER'S EMPLOYER ____________________________________ EMPLOYER'S PHONE # _______________

EMPLOYER'S ADDRESS____

I request the direct payment of authorized medical benefits (including Medicare, Medigap, major medical benefits) be made to **Visage Dermatology and Aesthetic Center, LLC** for any services furnished me by these physicians. I authorize any available benefits be issued to Visage Dermatology and Aesthetic Center, LLC. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing administration and its agents, to my attorney, or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not paid by the insurance carrier. I understand that if my account has to be forwarded to a collection agency, I am responsible for all collection fees, including court costs.

Beneficiary's Signature ____ Date _______________

CONSENT FOR TREATMENT: I authorize Visage Dermatology and Aesthetic Center, LLC and its Associates to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures etc.) as ordered by the physicians and/or other health care providers. Most tissue and cultures are sent to outside laboratories, if your insurance carrier requires a specific facility, please let our staff know at the time service is rendered. I acknowledge that no guarantee can or will be made as to the results of the care, treatment, and medication prescribed.

CONSENT TO RELEASE OF INFORMATION: I authorize Visage Dermatology and Aesthetic Center, LLC to release to my insurance carrier(s)- including Medicare, and any other reimbursing agency- information about my identity, treatment, diagnosis, prognosis, and/or services rendered (including drug and alcohol abuse treatment, mental health treatment; diagnosis and/or treatment of HIV, AIDS, AIDS- related illness or sexually transmitted disease) as permitted by state and federal law which may be required or requested, thus releasing Knott Visage Dermatology and Aesthetic Center from any liability for furnishing for furnishing such information. I understand information may be released through electronic or paper media.

NOTICE OF HEALTH INFORMATION PRACTICES: I acknowledge that the Notice of Privacy Practices is on file and I may access it at will.

CONSENT FOR PHOTOGRAPHY: I understand that for some procedures and for some skin conditions that photographs may be taken by Dr. St. Surin and Visage Dermatology Associates/staff to document progress or progression of hair, skin and/or nail conditions. I understand that photos taken by Dr. St. Surin and Visage Dermatology associates/staff may be also be used for the following: for my own record to document my baseline appearance, for insurance purposes if indicated, for academic teaching, for research purposes, journals, books, & / or chapters, for patient education, for use in a brochure for patient information / advertising/ internet-web page. If we want to use your photo for advertisement, we will still call you and verify this if full-face photography is required.

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Date Signature of Patient <u>or</u> Legally Authorized Representative

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Printed Name and Relationship to Patient, if not signed by patient