Date:11/29/2012
Time:11:58:25

Patient Registration

Boyle Family Dermatology

PATIENT'S AUTHORIZATION

I hereby authorize the physician to furnish information to insurance carriers concerning this illness / accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

All balances over 90 days will be charged a $50.00 rebilling fee. Patient is resposible for all cost in the collection of any debt to include but not limited to collection services, court cost and lawyer's fees.

Signature of Subscriber or Beneficiary _____ Date _____

Patient.Acct#: _____

Patient: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

_____ **Date of Birth:** ___/___/___

City,ST Zip: _____ **Soc Sec #:** ___-___-_____

Employer: _____ **Sex:** ___

Email: _____

Responsible: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

_____ **Relationship to Patient:**

City,ST Zip: _____ ☐ Self ☐ Parent ☐ Other

Ins1 Holder: _____ **Patient to Cardholder:**

☐ Self ☐ Child ☐ Other ☐ Spouse

Ins1 Co.: _____

Copay: _____ **Policy #:** _____ **Group #:** _____

Ins2 Holder: _____ **Patient to Cardholder:**

☐ Self ☐ Child ☐ Other ☐ Spouse

Ins2 Co.: _____

Copay: _____ **Policy #:** _____ **Group #:** _____

Refer Dr.: _____ **Phone:** _____

Address: _____

_____

Emergency: _____ **Phone:** _____

Acknowledgment of Receipt of Notice of Privacy Practices

Thank you for choosing Boyle Family Dermatolgy for your healthcare needs. We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign to acknowledge that you have been provided with a copy.

Name of Patient (Print) _____ Signature of Patient (or legal representitive) _____

Date of Birth: _____ Date of Signature: _____

Signature of Staff _____