

| NEW PATIENT REGISTRATION | |
|--|------------------------------|
| _____ | |
| (Last Name) | (First Name, Middle Initial) |
| Nickname / Name Preference: _____ | |
| Sex: _____ | Age: _____ |
| Birthday: _____ | |
| Patient SSN# _____ | |
| eMail _____ | |
| (Required for Patient Portal - we do not share this) | |
| Address: _____ | |
| _____ | |
| (city) | (state) (zip) |
| Employer: _____ | |
| Language: <input type="checkbox"/> English _____ | |
| Race: <input type="checkbox"/> White _____ | |
| Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Primary Doctor: _____ | |

| HELP US TO COMMUNICATE WITH YOU! | |
|--|--------------|
| _____ / _____ | |
| (Home Phone) | (Cell Phone) |
| Other: _____ | |
| Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other | |
| OK to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Emergency Contact: _____ | |
| _____ | |
| (Relationship) | (Phone) |
| <u>Appointment Reminders (3 days in advance)</u> | |
| May we send a reminder text? Yes _____ | |
| If no: <input type="checkbox"/> Voice Call to Preferred Phone <input type="checkbox"/> eMail <input type="checkbox"/> None | |

| INSURANCE, BENEFITS AND HIPAA ACKNOWLEDGMENT | |
|---|-------------------------------------|
| Primary Insurance Holder (if not the patient) | Secondary Insurance (if applicable) |
| Name: _____ | Name: _____ |
| (first) (last) | (first) (last) |
| Birthday: _____ SSN: _____ | Birthday: _____ SSN: _____ |
| Relationship to Patient: _____ | Relationship to Patient: _____ |
| Insurance Company: _____ | Insurance Company: _____ |

Payment and HIPAA Policies of Richard Assaf Dermatology, Inc

My signature or initials below indicate my understanding and acceptance of the following policies of RAD, Inc:

I will provide all insurance information including referrals, and authorize Richard Assaf Dermatology, Inc to file insurance claims on my behalf. **I will be responsible for payment in full if I do not.**

If my insurance company does not make payment, after two attempts have been made to obtain payment, the payment for services rendered becomes my responsibility regardless of the fact that I have insurance.

The custodial parent bringing a minor patient for services is responsible for paying any deductible, co-payment or co-insurance **at the time of service**. Unaccompanied minors shall come prepared to make payment.

I will give at least 24 hours notice if any appointment needs to be rescheduled, or pay a \$50 fee for a late cancellation or no-show appointment that could have been offered to another person in need.

There is a \$30 charge applied to insufficient checks, and to accounts referred for collections.

I acknowledge that I had the opportunity to review RAD, Inc's Notice of Privacy Practices. I also understand that I may request a username/password to access the RAD portal containing my visit information within 4 days of my visit, in accordance with HIPAA guidelines.

Signed: _____

Date: _____

(indicate relationship or POA if signing for someone else)