Welcome to Richard Assaf Dermatology

RAD

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: ☐ English _____

Race: ☐ White _____

Are you Hispanic or Latino? ☐ Yes ☐ No

Primary Doctor:

HELP US TO COMMUNICATE WITH YOU!

_____ / _____
(Home Phone) (Cell Phone)

Other: _____

Preferred Phone: ☐ Home ☐ Cell ☐ Other

OK to leave a message at this number? ☐ Yes ☐ No

Emergency Contact: _____

_____
(Relationship) (Phone)

Appointment Reminders (3 days in advance)

May we send a reminder text? Yes_____

If no: ☐ Voice Call to Preferred Phone ☐ eMail ☐ None

INSURANCE, BENEFITS AND HIPAA ACKNOWLEDGMENT

Primary Insurance Holder (if not the patient)

Name: _____
(first) (last)

Birthday: _____ SSN:_____

Relationship to Patient: _____

Insurance Company: _____

Secondary Insurance (if applicable)

Name: _____
(first) (last)

Birthday: _____ SSN:_____

Relationship to Patient: _____

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 in accordance with HIPAA guidelines.

Signed: _____ Date: _____

(indicate relationship or POA if signing for someone else)