Belaray Dermatology
P: (516)822-7546
https://www.belaray.com
TEXT: (516)433-7546

Patient Registration **Date: _____**

Patient Information (please complete using your name as listed on your insurance card)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of birth: _____ SS# _____

Marital Status:_____ Sex:____ Race:_____ Ethnicity:_____ Preferred Language: _____

Occupation: _____ Employer: _____

Pharmacy Name: _____ Street/ City: _____**Phone**:_____

Insurance Responsibility / Guarantor

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of birth: _____ SS# _____

Sex:_____ Occupation: _____ Employer: _____

Insurance Information All Patients must provide a copy of their insurance card at the time of their visits.

Primary Insurance: _____ID#: _____Group#_____

Relationship to Insured: __Self __Spouse __Child

Secondary Insurance: _____ID#: _____ Relationship to Insured: __Self __Spouse __Child

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How Did You Learn About Our Office?_____

Referring Physician: _____ Phone # _____

Primary Care: _____ Phone # _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

May We Leave A Message With Test Results On Your Answering Machine: Yes No

If YES, What phone number may we leave messages at: _____

HIPAA Policy Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Belaray Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Acknowledgements Belaray Dermatology Office Policies

HIPAA Policy I acknowledge a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 is available at any time both in the office, and at Belaray.com.

Patient Release Must be signed by patient if over 18 or by legal guardian of patient under 18. I certify that I hereby authorize Belaray Dermatology PC, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, or biopsy. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

Insurance Information Co-Payments and Deductibles Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances that are past due. Your signature below signifies your understanding and willingness to comply with this policy.

New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Referral Information If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; Belaray Dermatology will reschedule my appointment.

Cancellation Policy Should you be unable to keep your appointment, please contact our office at least 48 hours ahead of your visit. Failure to contact the office in a timely manner will result in a $25.00 fee. This fee is not reimbursable by your insurance company.

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

I attest that I have read, understand and agree to all of the terms and office policies listed above by signing my name below.

Signature:_____ Date:_____