Date: _____

COLUMBIA SKIN CLINIC

Patient Registration

(PLEASE PRINT)

Name: _____
Last Name *First Name* *Middle Initial* *Preferred Name*

Address: _____
City *State* *Zip Code*

Home Phone: _(____)_____ Cell Phone: _(____)_____ Work Phone: _(____)_____

Sex: _____ Date of Birth: _____ Age: _____ SSN: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed | Preferred Language: _____

Email Address (*for patient portal*): _____

Who may we thank for referring you?
□ Doctor (name: _____) □ Family: _____ □ Other: _____

RESPONSIBLE PARTY (if under 18): _____ Relationship to Patient: _____
Responsible Party SSN: _____ Responsible Party Date of Birth: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____
Subscriber Name: _____ Date of Birth: _____ SSN: _____
Relationship to the Patient: _____

Secondary Insurance: _____ Policy Number: _____
Subscriber Name: _____ Date of Birth: _____ SSN: _____
Relationship to the Patient: _____

PRACTICE POLICIES ACKNOWLEDGEMENT

I authorize treatment by the Columbia Skin Clinic provider(s). My signature below authorizes the release of my medical information to (1) my primary care and/or referring physician, to consultants if needed and any physician involved in my medical care; (2) any insurance company through which I claim benefits; (3) for processing insurance applications and prescriptions. I further authorize the assignment of all medical benefits to which I am entitled, including Medicare, MediGap, private insurance, group policy benefits, and other health plans to the Columbia Skin Clinic, LLC.

We wish to establish optimal relations with our patients and avoid misunderstanding regarding our payment and cancellation policies. Payment is required for all services at the time they are rendered unless you are in a plan in which we participate. For those patients, applicable copayments and deductibles will be collected. Any amount that your insurance company deems your personal responsibility is due from you. I understand that for cosmetic procedures a deposit is required at the time of scheduling and that the balance is due at the time of service. We accept payment in the form of cash, check, or credit card. I understand that a minimum notice of two (2) business days is required to cancel an appointment. Failure to provide sufficient cancellation notice may result in a no-show infraction and forfeiture of deposit. I also understand that three (3) no-show infractions may result in dismissal from the practice.

Your signature below signifies your understanding and willingness to comply with these aforementioned policies.

Patient/Responsible Party Signature _____ Date _____
(If under 18 years of age, a responsible party must sign.)

Rev 03/18