METRO DERMATOLOGY
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Patient Registration Form

(Updated in September 2024)

Patient Information

Name:
_____ _____ _____
Last First M.I.

Gender at Birth:
❑Male
❑Female

Pronouns: ❑ She/ her/ hers ❑ He/ him/ his ❑ They/ them/ theirs

Date of Birth: / /

Social Security No: - -

Street Address:

Apt. #:

City:

State:

Zip:

Email: @

Marital Status: ❑Single ❑Married ❑Other

Home #: ( ) -

Cell Phone #: ( ) -

**If you do Not want to receive text reminders, please inform the Front Desk staff.*

Preferred Language:
❑English ❑Español ❑한국어 ❑日本語
❑國語 ❑廣東語 ❑Other: _____

Emergency Contact:

Relationship:

Emergency Phone #: ( ) -

Primary/ Referring Doctor:

Dr. Phone #: ( ) -

Preferred Pharmacy Name:

Pharmacy Phone #: ( ) -

Insurance Information

Primary Insurance Name:

****Does your insurance require a referral to see a specialist?** ❑Yes ❑No

Subscriber's Name:
_____ _____ _____
Last First M.I.

Subscriber's DOB: / /

Relationship to Patient:

Signature: X_____ **Date**: _____/_____/_____

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HIPAA Privacy Authorization

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, Metro Dermatology (MD) does not disclose Protected Health Information (PHI) without your permission. Please provide the name(s) and phone number(s) of any person(s) other than yourself with whom we can discuss the following:

- Leave message regarding appointments, treatments, and/or test results.
- Discuss your appointments and billing issues.

Names of Authorized Individual(s) (Print)	Phone Number

___ (Initial)

Treatment Consent

I hereby authorize and consent to treatment at MD. This may include the administration of medication, diagnostic tests, and procedures as deemed necessary by my physician, or the physician's assistants or designees, for purposes of diagnosis or treatment.

___ (Initial)

Authorization & Assignment

I authorize MD to release any medical or other information required to process my insurance claim. I also authorize payment of my benefits to MD. I understand that I am financially responsible for any balance not covered by my insurance carrier.

___ (Initial)

Medicare Claims

MD accepts Medicare assignment for services provided. Patients are responsible for meeting their annual deductible and any coinsurance. As a courtesy, MD will also file with secondary/supplemental carriers if applicable. However, if the secondary carrier does not pay within 60 days, I will be responsible for the remaining balances.

___ (Initial)

Payment Guarantee

*** Patient Responsibility.** I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within thirty (30) days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether I am covered by an HMO, PPO, or a traditional group health plan.

If my account becomes delinquent, I understand that it is subject to placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance, including, but not limited to, collection agency fees, attorney's fees, filing fees, and court costs, when necessary, will be added to the balance referred.

*** Contracted Insurers.** If MD participates (is contracted) with my insurance plan, MD files claims as a courtesy to me. I understand that I am responsible for:
- Co-payments - Annual deductibles - Coinsurances - Non-covered services

*** Non-Covered Services.** Insurers routinely state, "The determination of benefit is made at the time the claim is received." MD often does not know if treatments will be covered until MD receives the insurer's EOB (explanation of benefits). After the EOB for my submitted claim has been received at MD, I will be billed for any items not covered by my insurance plan. Services may be denied for coverage because the carrier considers the services: 1) Medically unnecessary 2) for a pre-existing condition 3) cosmetic. If Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment**.**

*** Transfer of Credit Balance.** A credit balance resulting from payment to MD from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

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*** Pathology & Laboratory Charges.** Final laboratory charges cannot be anticipated at the time of service and are not within MD's control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. I will be responsible for for any amount not covered by insurance.

Fees

___ (Initial)

*** Co-Pay Rebilling Charge.** MD's contract with my insurer requires any co-payments to be collected in full at the time of service. If I ask to be billed for the co-payment rather than paying it at the time of service, a $10 service charge will apply for additional billing needed to collect the co-payment.

*** Insurance Charge**. If I do not provide the correct insurance information before my insurer's claim filing deadline, I will become responsible for the full cost of the visit.

*** Returned Checks.** There is a $25 processing fee for returned checks. Returned checks may also be forwarded to Metro Dermatology's collection agency for further action.

Appointment Cancellation or 'No Show' Policy

___ (Initial)

I will notify MD at least 24 hours in advance if I am not able to keep my appointment. A late cancellation (less than 24 hours' notice) is considered to be a "No Show." I understand that "No Shows" may be charged a $50.00 fee. I understand that leaving a message on the answering machine is not an acceptable cancellation. **I understand that this charge is not billable to any insurance carrier.**

I agree to provide a credit card number, which may be charged $50 for any no-show of a scheduled appointment.

* I understand that I must cancel or reschedule an appointment at least 24 hours in advance to avoid a potential no-show charge to the credit card provided**.**

Appointments may be canceled by calling 718-886-9000 when I receive the appointment confirmation link. MD will help me to reschedule the appointment if needed.

Medication Refills

___ (Initial)

Patients are given enough medication to cover them until their next visit. A follow-up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given.

No Insurance Card

___ (Initial)

All patients MUST present their insurance card(s) and photo ID on their first visit, and whenever there are any changes to their insurance. Due to recent unfortunate insurance fraud incidents, MD will not be able to provide services to patients who do not present their insurance card(s) and a photo ID at the time of service. If I do not have my insurance card or photo ID, I will need to reschedule my appointment**.**

If I want to be seen without my insurance card for my first visit, I understand that I will be charged the standard commercial fee.

Photo Consent and Release

___ (Initial)

MD or their representative may capture photographs and/or video recordings of me for inclusion in my medical file. In addition, I give MD permission to use de-identified images of conditions for medical training or marketing purposes. I consent to the use of these images without claiming any ownership rights or entitlement to royalties.

Signature: X_____ **Date**: _____ / _____ / _____

We will store your credit card information with a third-party vendor, **Stripe. Stripe stores the information on a separate, secure site. This enables us to run credit card transactions within our system. Office personnel will not have access to your card information. Only the last 4 digits of your card will show in our system.*