John K. Wildemore MD, LLC
Dermatology & Dermatologic Surgery

Welcome To Our Office - Please Complete the Following Patient Registration Information

Last Name: _____ First: _____ M.I.: _____

Date of Birth ____/____/____ Gender: M F Preferred Language _____

As required by Medicare: **Race:** White African American Asian Native American Other **Ethnicity:** Hispanic Latino Neither Refuse to Report

Marital Status (circle): Single Married Domestic Partner Divorced Widowed

Mailing Address _____

City _____ State _____ Zip Code _____

E-mail Address _____

Occupation _____ Employer _____

I was referred by _____

Primary Care Physician Name & Phone Number _____

Pharmacy Name _____ Location _____ Phone Number _____

To respect your privacy, please list only phone numbers where we may call AND leave messages:

Home _____ Work _____ Cell _____

Emergency Contact _____ Relationship _____ Phone Number _____

Do you give permission to discuss your confidential medical information with a family member or other person? **YES NO**

(IF YES, please provide information below and phone number where message can be left.)

Name _____ Phone number _____ Relationship _____

An insurance card will be required at each visit if you would like us to bill your participating insurance plan(s).

IF YOU ARE NOT THE RESPONSIBLE PARTY (i.e., you are insured under the plan of a spouse/parent) please list guarantor information below:** ***Relationship to Patient:

Last Name _____ *First* _____ *M.I.* ____ *Parent Spouse Other*

Date of Birth ____/____/____ *Telephone number(s) Home* _____ *Cell:* _____

Mailing Address _____

City _____ *State* _____ *Zip Code* _____

The above is true and correct to the best of my knowledge: *(If under age 18, signature of parent or guardian)*

Signature _____ Date _____

744 W. Lancaster Avenue ● Wayne PA 19087
Phone: 610-688-8750 ● Fax: 610-688-8751

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Financial Policies and Consents

We make every effort to provide the finest dermatologic care and appreciate your assistance in facilitating payment to ensure we can continue to do so. Payment is due in full at the time of service, including co-payments, co-insurance and unmet deductible portions when applicable. Our billing service (Dermatology Billing Associates) will submit a claim to your insurance company and should a balance be due, they will issue a bill.

Please note: Your health insurance coverage is a contract between you and your insurance company - ultimately you are fully responsible for all fees charged regardless of your insurance coverage. It is your responsibility to be aware of any restrictions, limitations and requirements of your policy, including whether or not any 'out-of-network' restrictions apply. Although a service may be 'covered' by your insurance plan, depending on any deductible, co-payment or co-insurance due, you may be responsible for all or part of the 'covered' amount.

Financial policies:

- **If we are unable to confirm your insurance coverage a deposit or payment in full may be required at the time of service.**
- **Patients requiring a referral are responsible for obtaining referrals prior to the appointment. We cannot do this for you. If there is no referral at the time of your appointment, you may have to reschedule your appointment or be responsible for full payment.**
- **Biopsy and surgical specimens are sent to an outside lab – the lab will bill your insurance separately for their services.**
- **Missed appointments or those cancelled with less than 24 hours notice may be assessed a $50 cancellation fee.**
- **Checks returned by your bank are subject to a $30 processing fee.**
- **Any unpaid balances 90 days past due will be sent to a collection agency – all fees associated with the collection process (including the collection agency's commission) will be added to the total balance due.**
- **We are participating providers with MEDICARE and accept assignment on all medically necessary claims. Our billing service will submit claims to both Medicare and secondary/supplemental carriers. Medicare patients are responsible for meeting their annual deductible and paying the 20% co-payment.**
- **We do NOT participate in MEDICAID plans. By signing below, you agree that you DO NOT have any type of Medicaid insurance and that if you should obtain any such insurance in the future you will inform our office in writing. If you have any Medicaid insurance and do not provide accurate information regarding this, you will be fully responsible for any balance due.**

Consents:

1. **Financial Policies:** I hereby certify that I have read, understand and agree to abide by the above financial policies. I authorize direct payment of insurance benefits to John K. Wildemore, M.D., LLC for services rendered.
2. **Medical Treatment & Photographs:** I consent to examination, performance of tests & procedures and medical photographs during the course of my care in the practice of John K. Wildemore, M.D., LLC, by the medical provider and/or his or her assistants.
3. **Release of Medical Information:** I authorize John K. Wildemore, M.D., LLC to furnish my primary care physician, referring physician, and any other medical professionals involved in my care with any health information necessary regarding my physical/mental condition and/or any treatments/conditions associated with my care. I also authorize the release of medical information as necessary to my insurance company and associated institutions/agencies for payment of benefits.
4. **Receipt of HIPAA Notice of Privacy Practices:** I have had the opportunity to review a copy of this practice's HIPAA Notice of Privacy Practices and all of my questions have been answered to my satisfaction. By signing below, I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I understand that the terms of the Notice may change, and if they do, a revised copy may be obtained by contacting the office. I understand I have the right to revoke this consent in writing. However, such a revocation shall not affect any disclosures that have already been made in reliance on my prior consent

My signature below indicates that I have read, understand, agree to and consent to all of the above statements. My authorization shall remain in force until revoked in writing by the undersigned.

Patient Signature (or parent/guardian if patient under 18)_____**Date**_____

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