Johnson Dermatology Patient Registration Form

Patient Information					
Full Name:					
Street Address or P.O. Box:					
City, State, and Zip Code:					
Date of Birth:			Social Security Number:		
Phone Numbers	Home:				
	Mobile:				
	Work:				
E-mail Address:					
Place of Work (name of company and city):					
Marital Status	☐Single	☐Married	☐Divorced	☐Widowed	
Sex	☐Male	☐Female			

☐ Please mark this box if we may not use your email to contact you about clinic matters

Authorization to Release Health Information		
List any individuals with whom we can discuss your care – for example, your spouse or child.		
Person One	Name:	Relationship to Patient:
	Phone Number:	Work or Other Phone Number:
	Place of Work (name of company and city):	
Person Two	Name:	Relationship to Patient:
	Phone Number:	Work or Other Phone Number:
	Place of Work (name of company and city):	
Person Three	Name:	Relationship to Patient:
	Phone Number:	Work or Other Phone Number:
	Place of Work (name of company and city):	
☐ Only discuss my health care with me		

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Parent or Guardian Information		
(complete only if the patient is less than 18 years old)		
Full Name:		
Relationship to the Patient:		
Address:		
Date of Birth:		Social Security Number:
Phone Numbers	Home:	
	Mobile:	
	Work:	
E-mail Address:		
Place of Work (name of company and city):		

Insurance Policy Holder Information		
(complete only if the person responsible for medical payments is someone other than the patient)		
Full Name:		
Relationship to the Patient:		
Address:		
Date of Birth:		Social Security Number:
Phone Numbers	Home:	
	Mobile:	
	Work:	
E-mail Address:		

Insurance Information	
(complete only if you do not have your insurance card with you)	
Name on Insurance Card:	
Social Security Number of Cardholder:	
Insurance Company:	
Address of Insurance Company:	
Group Number:	ID Number:

Johnson Dermatology Credit Card Financial Policy

Effective: 06-01-08

1. All patients are required to complete Johnson Dermatology Patient Registration Form, Consent to Treatment, Insurance Forms, Request for Credit Card Information before clinic services are offered.
   a. These forms will be scanned into the patient chart under documents
2. All patients are required to pay for services performed.
   a. Payment is required at time of service for cosmetic and patient pay.
   b. Co-payment is required at time of service.
   c. Co-payments and Deposits will be entered in the unapplied credits and tracked in the billing journal as appropriate.
3. Insurance will be filed for all primary insurance plans when information is given.
4. Insurance will be filed for all secondary insurance plans. We will not file secondary insurance when Medicaid is the secondary insurance and Medicare is not the primary insurance plan.
5. We will not file tertiary insurance.
6. Messages for payment will be entered on encounter form
   a. Co-payments will be listed
   b. Credit Card, Deposit or waiver will be listed
7. Credit Card Payments (see forms explaining Credit Card information)
8. All patients are expected to provide credit card information or leave a $100 deposit at the time of service. Waivers will be allowed if:
   a. Medicare is the primary insurance and there is a secondary insurance
   b. Medicaid is the primary insurance
   c. Patient states a financial hardship but agrees to make a minimal deposit
9. A $5.00 fee will be added for each 30 days that a balance is left unpaid after a statement has been sent to the patient.
10. All reasonable attempts will be made to obtain payments for services.
    a. Three statements will be sent
    b. One phone attempt will be made
    c. Without payment, the balance will be sent to an outside collection agency and the patient will be blocked from further clinic services.
11. The financial policy will be enforced by all clinic personnel. Please direct any concerns or questions to Sandra Johnson MD (general manager) and Lynne McCartney CDC (billing manager).

Please keep this page for your records