REGISTRATION FORM

Please enter information EXACTLY as printed on your insurance card.

DATE	ACCOUNT#	PATIENT#	SSN#
FIRST NAME	MIDDLE INITIAL		LAST NAME
ADDRESS (STREET, CITY, STATE & ZIP)			
HOME PHONE	WORK PHONE		CELL PHONE
AGE / BIRTH DATE		Sex	MARITAL STATUS
YOUR EMPLOYER		EMAIL	
IF STUDENT CIRCLE ONE FULL-TIME PART-TIME		REFERRAL SOURCE OR REFERRING DOCTOR	

PERSON FINANCIALLY RESPONSIBLE FOR THE BILL (GUARANTOR)

FIRST NAME	MIDDLE INITIAL	LAST NAME	
THEIR ADDRESS (STREET, CITY, STATE & ZIP)			
RELATIONSHIP TO GUARANTOR	HIS/HER BIRTHDATE	HIS/HER SSN#	HIS/HER HOME PHONE#
HIS/HER EMPLOYER		HIS/HER WORK PHONE#	HIS/HER MOBILE PHONE#

INSURANCE INFORMATION

PRIMARY INSURANCE:	INSURED'S NAME:
INSURED'S BIRTH DATE:	INSURED'S SS #:
SECONDARY INSURANCE:	INSURED'S NAME:
INSURED'S BIRTH DATE:	INSURED'S SS #:
THIRD INSURANCE:	INSURED'S NAME:
INSURED'S BIRTH DATE:	INSURED'S SS #:

RELEASE OF INFORMATION

Your signature authorizes Center of Dermatology, P.C. to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Center of Dermatology, P.C. when an assigned claim is filed. You also certify that all of the information that you have provided to Center of Dermatology, P.C. is complete and accurate. A photocopy hereof shall be valid as the original.

* PAST DUE INVOICES ARE SUBJECT TO A 1.33% PER MONTH INTEREST CHARGE *

YOU MUST BE 19 YEARS OLD OR OLDER TO SIGN

SIGNATURE: _____ **DATE:** _____

PLEASE PRESENT INSURANCE CARDS AND PHOTO I.D. TO THE RECEPTIONIST SO COPIES MAY BE MADE.

CENTER OF DERMATOLOGY, P.C.
HERSCHEL E STOLLER, M.D

CONCERNING YOUR INSURANCE

We will file your insurance:

1. When we are a provider for your insurance program or
2. When your account is paid at the time of service.

In order to file your insurance, we must have the following information:

1. A photocopy of your insurance card.
   This should have the policy number, group number, insured's name, and the address and telephone number of the insurance company.
2. Insured's birth date
3. Insured's Social Security number
4. Insured's place of employment

We cannot file an insurance claim without all of this information.

CONCERNING MEDICARE BENEFITS

This office accepts assignment for Medicare patients. This means that we will submit a claim for you and agree to accept Medicare's fee schedule. You are responsible for the annual 100% deductible and 20% of the amount approved by Medicare. Medicare pays 80% of the approved amount. If you have any questions, you can reach the Medicare Beneficiary Line at 1-800-633-1113.

CONCERNING YOUR MANAGED CARE INSURANCE

You must have a referral from your Primary Care Physician, if your insurance requires one.
Arrangements for the referral are your responsibility.
If you do not have a referral for your office visit or authorization for service, you are responsible for payment in full.

CONCERNING NON-COVERED SERVICES

Payment for services that are considered cosmetic and charges that are not eligible for payment by your insurance company are your responsibility.

PATIENT AGREEMENT:

1. **I AGREE TO PAY THE COPAY, DEDUCTIBLE AND COINSURANCE; WHICHEVER ARE APPLICABLE.**
2. **I AGREE TO PAY THE COPAY AT THE TIME OF MY APPOINTMENT. I AGREE TO PAY A $5.00 BILLING CHARGE IF I FAIL TO PAY MY COPAY WITHIN 7 DAYS OF THE APPOINTMENT.**
3. **I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT IF I FAIL TO OBTAIN A REFERRAL OR AUTHORIZATION FOR SERVICE WHEN REQUIRED BY MY INSURANCE PLAN.**
4. **I AGREE TO PAY FOR ALL NON-COVERED SERVICES.**
5. **I AGREE TO PAY A $35.00 FEE FOR ANY RETURNED CHECKS.**
6. **I AGREE TO PAY A 1.33% PER MONTH LATE CHARGE ON PAST DUE INVOICES.**

SIGNED:_____**DATE:**_____

HERSCHEL E STOLLER, M.D.
CENTER OF DERMATOLOGY, P.C.
10110 NICHOLAS STREET, SUITE 103
OMAHA, NEBRASKA 68114-2185
(402) 398-9200 FAX (402) 398-9400

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME_____

DATE OF BIRTH _____

SIGNATURE_____

DATE:_____