Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

PATIENT INFORMATION (Please Print)

Patient's Legal Name: (Last)_____ (First)_____ (MI)_____

Address:_____

City:_____State: _____Zip:_____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Email Address:_____

Patient's Social Security Number:_____

Preferred Method of Contact: ☐Text ☐Phone Call ☐Email

Patient's Date of Birth: MM_____ DD_____ YYYY_____ Gender: ☐Male ☐Female

Primary Care Provider: _____

Employment: ☐Not Employed ☐Employed Employer:_____

Emergency Contact Name: (Last)_____(First)_____

Relationship to Patient:_____ Phone Number: _____

Marital Status: ☐Single ☐Widowed ☐Married Name of Spouse:_____

Do we have permission to discuss financial/appointment information, biopsy or other test results, or upcoming/missed appointments with a member of your household? ☐Yes ☐No

If yes, whom:_____ Relationship to Patient: _____

Do you have health insurance? ☐Yes ☐No Name of Plan:_____

Policy Holder Information

Name: (Last)_____ (First)_____ (MI)____

Date of Birth: MM _____DD _____YYYY_____ Relationship to Patient:_____

Address: _____

Name of Preferred Pharmacy: _____

Location/Address:_____ Phone Number: _____

CONSENT FOR TREATMENT

I am voluntarily seeking medical care and hereby consent the medical treatment, procedures, laboratory tests, and other health care services provided or referred by Larry E. Urry, M.D. or any other medically credentialed provider(s) under the direction of Draper Dermatology. This agreement will remain in effect until I choose to revoke it in writing.

Patient or Parent/Legal Guardian Signature: _____Date:_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Draper Dermatology's privacy policy.

Patient or Responsible Party Signature: _____ Date: _____

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES

In my absence, I authorize Draper Dermatology to release all or portions of my, or my dependents, medical record(s) to those indicated below (i.e. lab results, prescriptions, etc.). This authorization is in effect until I revoke it in writing. Please consider others who may bring your children in for care, such as a relative or guardian.

Name:_____ Relationship: _____ Phone:_____
Name:_____ Relationship: _____ Phone:_____

Patient or Parent/Legal Guardian Signature: _____ Date: _____

CREDIT AND FINANCE POLICY AND AGREEMENT

I agree to be financially responsible for all medical and/or aesthetic bills that result from services rendered by individuals employed by Draper Dermatology on my, or my dependent's, behalf. If medical claims are submitted to an insurance company by Draper Dermatology on my behalf, **I understand that the copayment or deductible is due at the time the care is rendered.** I hereby authorize any benefits due to me to be paid directly to Draper Dermatology (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "not-medically necessary" by my third-party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

I understand and agree that patients without insurance and/or using cash-pay services are to pay in full upon checkout on the day of service. Delinquent accounts may be charged an interest rate of 13% per annum (1.0833% per month) or a minimum of $0.65 monthly finance charge, whichever is greater, which is due and payable upon receipt of statement. **In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 33% of the unpaid balance.** In the event of a lawsuit, to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees in addition to the collection fee.

I authorize Draper Dermatology to call me at any number I provide or at any number that Draper Dermatology reasonably believes we may contact you (including calls to mobile, cellular, or similar devices) for any lawful purpose. I agree to pay any fee(s) or charge(s) that I may incur for incoming calls from Draper Dermatology, and/or outgoing calls to Draper Dermatology, to or from any such number, without reimbursement from Draper Dermatology.

There is a 24-hour cancellation notice required for all appointments. Draper Dermatology reserves the right to charge $50 for a missed office visit, $100 for a missed surgery appointment, and up to $150 for a missed hair removal, facial, peel, laser, or other medical or aesthetic appointment.

Patient or Responsible Party Signature: _____ Date: _____