PATIENT INFORMATION: DATE: _____

NAME:_____ Mr. Mrs. Ms. Miss
Last First MI Circle one

PHONE: (H)_____(W)_____ (C) _____

ADDRESS:_____
Street Address City State Zip Code

BIRTHDATE:_____/_____/_____ AGE: _____ SSN:_____ SEX: M_____F_____

OCCUPATION:_____EMPLOYER:_____

MARITAL STATUS:_____ SPOUSE'S NAME: _____

PATIENT'S PERSONAL PHYSICIAN:_____

***REFERRED BY*?**:_____ MD/PA/NP ***WHICH OFFICE*?:** _____
Circle one

EMERGENCY CONTACT:_____
Name Relationship Phone #

BILLING INFORMATION: (Write ***"same"*** if patient, otherwise please provide information) *If **STUDENT** please put parents information here.*

RESPONSIBLE PARTY: _____
Last First MI

ADDRESS:_____
Street Address City State Zip Code

INSURANCE:

PRIMARY INS CO:_____POLICY HOLDER'S NAME: _____ D.O.B. (____/____/____)

EMPLOYER: _____ RELATIONSHIP: _____ SSN: _____

SECONDARY INS CO: _____POLICY HOLDER'S NAME: _____ D.O.B. (____/____/____)

EMPLOYER: _____ RELATIONSHIP: _____ SSN: _____

PRIVACY NOTICE
PLEASE READ, SIGN AND DATE

I acknowledge that I understand the privacy policies mandated by the Health Insurance Portability and Accountability Act (HIPAA) that went into effect April 14, 2003.

SIGNED:_____ DATE: _____

RESPONSIBLE PARTY SIGNATURE IF PATIENT IS A MINOR: _____

FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION
PLEASE READ, SIGN AND DATE

I request that payment of authorized Medicare / Medigap or other insurance benefits be made on my behalf to the Fort Collins Skin Clinic for any services furnished to me by either physician / supplier. I authorize the Fort Collins Skin Clinic to release to the Health Care Financing Administration and its agents or my insurance company any information needed to determine these benefits payable for related services. **I understand that I am responsible for understanding my insurance coverage. I understand that prior authorization of services does not necessarily guarantee payment. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.**

SIGNED:_____ DATE: _____

RESPONSIBLE PARTY SIGNATURE IF PATIENT IS A MINOR: _____

Fort Collins Skin Clinic
Permission to Release Medical Information

The Fort Collins Skin Clinic has my permission to leave personal medical information in the following locations in the event that I cannot be reached directly:

Please Initial:

YES	NO	N/A	
____	____	____	Home answering machine/voicemail
____	____	____	Cell Phone
____	____	____	Work voicemail
____	____	____	OK to discuss info / results with Family member: _____ Relationship: _____ Phone number: _____

_____ _____
Print Name Date of Birth

_____ _____
Signature Date

_____ _____
Witness Date