Moeller Dermatology
Patient Information

Patient Demographics

Patient's Name: _____
First Middle Initial Last

Home Address: _____
Street City State Zip

Gender:
Date of Birth _____M_____F_____ Marital Status M S D W **Preferred method of contact for reminders**:
☐ **Phone Call** ☐ **Text** ☐ **Email**

Home Phone: _____Work Phone_____Cell Phone_____

Patient's Employer: _____Occupation:_____Email Address:_____

Policy Holder Demographics

Policy Holder Name: _____Relationship to Patient:_____

Home Address: _____
Street City State Zip

Birth Date: _____SSN_____Contact #_____Employer_____

This information must be completed in order to process your claims. If we do not receive this information you could be responsible for payment in full.

☐ **Responsible Party for a Minor** ☐ **Emergency Contact**

Name:_____Contact Phone:_____Relationship:_____

☐ **Responsible Party for a Minor** ☐ **Emergency Contact**

Name:_____Contact Phone:_____Relationship:_____

Referring Physician:_____ **Primary Care Physician (If different)**:_____

Would you like to receive The Moeller Dermatology Newsletter by email? ☐ **YES** ☐ **NO**

Acknowledgement of Receipt of Privacy Notice and Receipt of Patient Financial Policy

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of August 2016. I also acknowledge that I have received a copy of the current Patient Financial Policy. I understand that the policies are subject to change without notice.

ONE TIME AUTHORIZATION:

I request that payment authorization for Medicare Benefits be made either to me or on my behalf to Moeller Dermatology, LLC for any services furnished to me by the provider. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I hereby assign payments directly to Moeller Dermatology, LLC for any surgical and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance. I also understand that regardless of insurance coverage, I am financially responsible for all services rendered. I authorize Moeller Dermatology to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company.

PHOTOGRAPHS:

I understand that photographs taken before, during, or after the procedure may be used for documentation or teaching purposes.

_____
Patient Name (Please Print)

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient