WELCOME TO ROCK CREEK DERMATOLOGY

Patient Information		
Patient Name:	M F	Date of Birth:
Social Security #:	Marital Status: Single Married Widowed Divorced	
Home Address:		Zip Code:
Preferred Contact Number:	Circle one: Cell Phone Work Phone Home Phone	
Email Address:		
Name of Employer:		
Occupation:		
Referring/Primary Physician:	Physician Phone #	

Insurance Information/Responsible Party	
Primary Insurance:	Secondary Insurance:
Primary Cardholder's Name:	Secondary Cardholder's Name:
Primary Cardholders Date of Birth:	Secondary Cardholders Date of Birth:
Relationship to Patient:	Relationship to Patient:

Emergency Contact	
Name:	
Phone Number:	Relationship to Patient:

HIPAA & Notice of Privacy Practices

HIPAA refers to health insurance portability and accountability act. It is a law enacted by congress in an attempt to protect your medical and personal information. Our Notice of Privacy Practices provides details on how your medical information is used, how/why it may be disclosed, and how you may access it. For a more detailed description, please see our website or ask a staff member for a copy.

Financial Policy

I hereby authorize payment directly to the physician for Medical and/or Surgical benefits, otherwise payable to me for her services as described. I certify that the information I have reported is correct. I acknowledge that it is the policy of this office to collect any co- payments, co-insurances and/or deductibles at the time of each visit. I am also responsible to notify the office of any change in my insurance prior to my visit. If I have an HMO plan, I will select my PCP prior to my office visit. I understand that I am financially responsible for services that are not covered by my health insurance, or if payment is denied. I agree that in the event I do not pay for services provided, I will pay for the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that in the absence of a payment plan that the practice reserves the right to deny future services until payment is received and outstanding balances may accrue interest per month after 30 days. Appointments cancelled within 24 hours of their scheduled time may be subject to a $20.00 cancellation fee and a deposit of $40.00 may be required to book future appointments.

Your signature below acknowledges your understanding and agreement to the above stated policies.

Patient/Guardian Signature

Date