BEND DERMATOLOGY
CLINIC
DERMASPA

REGISTRATION FORM

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Home Phone

Billing / Mailing Address			Employer Phone

City	State	Zip	Cell Phone

Birthdate	☐ Single ☐ Married ☐ Divorced ☐ Widowed	Sex ☐ Male ☐ Female	Emergency Phone

Email Address	Social Security #

Employer	Occupation

PRIMARY INSURANCE / SECONDARY INSURANCE

Insurance Company	Insurance Company

RESPONSIBLE PARTY

Guarantor (if patient is minor)	Relationship to Patient	Birthdate

Address (if different than above)	Phone

MISCELLANEOUS INFORMATION

Primary Care Physician _____

New Patient: How were you referred: ☐ Mailer ☐ Walk-by ☐ Yellow Pages ☐ Internet ☐ Gift Certificate

☐ Friend _____ ☐ Physician _____

CANCELLATION POLICY

Bend Dermatology Clinic

- A 24 hour notice is required for cancellations. A $25 fee may be charged if a 24 hour notice is not provided.

DermaSpa

- A 48 hour notice is required for cancellations. Cancellations for Monday must be phoned in on the prior Friday. If notice is not provided, you will be charged the full price for the scheduled service.
- If you are not satisfied with your cosmetic service or product, please contact your skin specialist within 24 hours after your appointment to correct the situation. It is our policy to provide you with the best professional services and products customized for your skin condition.
- Cosmetic procedures are to be paid in full at time of service.
- All prices are subject to change without notice.

Initial _____

ASSIGNMENT AND RELEASE

I assign direct payment from my insurance company to Bend Dermatology Clinic for all medical services rendered. I understand my signature authorizes payment and the release of medical information necessary to process the claim. I understand that I am financially responsible for all charges whether or not paid by insurance.

In Medicare assigned cases, Bend Dermatology Clinic agrees to accept the charge determination of the Medicare carrier as the full charge. I understand that I will be billed only for the deductible, coinsurance, and non-covered services based on the determination of the Medicare carrier.

_____ _____

Signature of Patient, Client, or Responsible Party Date