Dermatology ASSOCIATES of Northern Kentucky

JAMES A. ZALLA, M.D. MARK J. ZALLA, M.D. SUSAN J. BUSHELMAN, M.D. MOLLY G. EISNER, M.D.
MAE L. DINN, MPAS, PA-C KRISTIN D. KENNEDY, APRN MARIE N. SARTORI, APRN

Registration Form

Patient Information (Please Print)

Last Name:	First Name:		Middle Name:		Prefix:
Address:		City/State:		Zip:	Nickname:
DOB:	Age	S.S. #		Home Phone:	
Employer Name:		Employment Status: ☐ Full time ☐ Retired ☐ Part time ☐ Not Employed		Cell Phone:	
Referring Physician:		Marital Status: ☐ M ☐ S ☐ D ☐ W		Preferred Way of Contact:	
Pharmacy Name/Location:		Pharmacy Number:		Primary Care Physician:	
Email:	Language: ☐ English ☐ Other_____		Race:	PCP Phone#:	

☐ Same as patient Responsible Party Information (If different from patient)

Person who accompanies child to visit

Last Name:	First Name:		Birthdate:
Address:		S.S. #	Relationship to patient:
Home Phone:	Cell Phone:	Work Phone:	

Emergency Contact (spouse or nearest relative)

Emergency Contact Name:	Phone Number:
Is it OK to leave message with ER contact? ☐ Yes ☐ No	Relation to Patient:

Primary Insurance Information

Insurance Company:	Group# / Plan ID:		Member Number:
Subscriber Employer Name:	Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other		Sex: ☐ M ☐ F
Subscriber Name:	Subscriber DOB:		Copay:

Secondary Insurance Information

Insurance Company:	Group# / Plan ID:		Member Number:
Subscriber Employer Name:	Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other		Sex: ☐ M ☐ F
Subscriber Name:	Subscriber DOB:		Copay:

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Dermatology Associates of Northern Kentucky to render needed treatment and/or tests for the above named patient.
2. I authorize Dermatology Associates of Northern Kentucky to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to Dermatology Associates of Northern Kentucky, realizing I am responsible to pay noncovered and unauthorized service.
4. If you are unable to keep your appointment, 24 business hour cancellation notice is required. If you miss your appointment or cancel without notifying our office at least 24 business hours prior, you will be charged $25.00 for each missed office appointment, and $100.00 for each missed surgery appointment. This charge is not billable to your insurance. **If you are more than 30 minutes late for an appointment, you may need to reschedule.**
5. We will need to make copies of your photo ID and Insurance Card(s)
6. Return Check Fee, you are charged $35.00 if your check is returned from the bank.

_____ _____

The above information is correct / Patient or Guardian Signature Date

(over)

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Financial Policy

1. All co-pay / co-insurance amounts are due at each visit or procedure.
2. Charges not covered by insurance are due at the time of service.
3. Balances remaining after insurance payment, are due within 30 days.
4. Any unpaid balance after 90 days will be charged a service charge / late fee.
5. We accept cash, check, Visa, Mastercard and Discover.
6. There is a returned check fee of $35.00 for any checks returned without payment from your bank.

Surgery

1. Insurance benefits for surgery will be verified through your insurance carrier.
2. For surgery, a prepay deposit may be requested, depending upon your out-of-pocket expenses as quoted by your insurance carrier.

Collection Accounts

1. **If you allow your account to go to collection, you are notifying our office that you are terminating the doctor / patient relationship.**
2. If your account has been sent to collection, after paying the entire balance plus late fees, you will be on a PAYMENT AT TIME OF SERVICE for one year. You then will be permitted to return to a normal pay structure.
2. If your account has been sent to collection TWICE, you may return to our office after clearing your collection balance and fees. You will be put on a permanent PAYMENT AT TIME OF SERVICE basis.
3. Accounts are sent to collection starting at 90 days unless payment arrangements have been made. You will be responsible for balance due and late fees of 1.5% / 18% annually.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE. PAYMENT IS EXPECTED AT THE TIME OF MY VISIT. IF THIS CAN NOT BE DONE, I AGREE TO MAKE OTHER ARRANGEMENTS WITH THE BILLING DEPARTMENT. I ALSO AGREE TO PAY ANY FEES FROM ANY PAST DUE AMOUNTS.

Patient _____ Date _____