HERNDON DERMATOLOGY - Anh P. Dang-Vu., M.D., P.C.

REGISTRATION INFORMATION

Date__________________________________ Referred by:____

Patient's Name (Last name):_______________________________(First name):______________________

Responsible party (if a minor): __________________________ Relation to patient: ____________________

Street Address:____________________________________ City, State, Zip:_____________________________

Sex: □ M □ F Age: ______ Birth-date: _______________________________□ Single □ Married □ Widowed □ Separated □ Divorced

Phone(H)______________________________________(W)____

Cell Phone:_______________________________E-Mail____
We would like to send you all appointment reminder via text

Occupation:__________________________________ Patient Employed by:__________________________________

Employment Address:____

Spouse's or Parent's Name:____

Occupation:____ Employed by:_____________________________________

Employment Address: ____

Has anyone in your family been seen in this office? ____

List their names:____

Insurance Information (Payments/Co-pay Required at Time of Service, Unless Prior Arrangements Have Been Made)

Insurance Company Name   Policyholder & Date of birth   Policy Number

1.____

2.____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to **Dr. Anh P. Dang-Vu**, for the services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance/ Medicare.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Dr. Anh P. Dang-Vu**, to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.

RECEIPTS OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

I certify that I have received a copy of Dr. **Anh P. Dang-Vu's** Notice of Privacy Practices.

A photocopy of these assignments shall be valid as the original.

Signature:____(Print Name)_____________________________

Parent's/Guardian Signature:____

HERNDON DERMATOLOGY - Anh P. Dang-Vu, M.D., P.C.

INFORMATION REGARDING OUR PRACTICE

We currently participate with several insurance plans. Please check with our staff. For us to process your insurance claims properly we ask that you to provide us with adequate information. By signing the necessary forms during registration, we will be happy to file your claims for you.

If your insurance plan requires you to have a referral, it is the patient's responsibility to obtain the referral not our doctor's office. Be prepared to pay in full for your services if you arrive without a referral. It is also your responsibility to be informed as to what services your insurance plan will and will not cover. We cannot adjust charges or diagnosis codes after services have been provided. Co-pays are paid at the time of your visit. If your insurance company denies payment for your charges, your balance must be paid within 60 days. We do use a collection agency to assist in collecting unpaid balances. Any balances remaining after insurance has paid will be billed to you. There is a $25 returned check fee.

Because your insurance policy is an agreement between you and your carrier, disputes related to your coverage are to be handled by you and your insurance company.

We ask for 24-hour notice for cancellations. We will charge a $30 fee for appointments not kept and cancellations received the same day. Reminder calls are done only as courtesy.

Please provide our front office staff with accurate and up to date information. By doing so we can process your claims more efficiently. Most importantly, please fill out your patient information neatly. If we cannot read your hand-writing we cannot contact or accurately file your claims for reimbursement.

PATIENT FINANCIAL AGREEMENT

I hereby authorize **ANH P. DANG-VU, MD, PC** to apply for benefits on my behalf for services rendered. I certify that the information I have reported about my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance company to determine these benefits payable. I request that payment of authorized benefits to be made to **ANH P. DANG-VU, MD, PC** on my behalf. I further acknowledge and understand the following:

1. **ANH P. DANG-VU, MD, PC** participates with certain HMO/PPO programs. If I am covered by an HMO or PPO that the office participates with, I agree to pay my co-payment at the time of service.
2. Commercial insurance participants may be required to pay in full for charges at time of service. As a courtesy**, ANH P. DANG-VU, MD, PC** will submit insurance claims on my behalf requesting that payment be made directly to them. If the commercial insurance carrier agrees to pay the physician directly, I will be required to pay any deductible (if not met) or any applicable co-insurance amounts.
3. I understand that I am financially responsible for any non-covered and / or denied charges incurred on my behalf.
4. I understand that for my office consultations with **ANH P. DANG-VU, MD, PC** without a proper referral for the date of service, I will be held financially responsible for the office visit.
5. I understand that if I do not provide the office with the proper insurance information at the time of service, I will be held financially responsible for the visit.
6. A copy of this agreement may be used in place of the original.

Please sign below to indicate that you have read and understood the information above.

____

Patient/Parents/ Guardian Signature Date

WAIVER FOR PERMISSION TO REPORT LAB RESULTS

We would like to ensure that you are notified of your test results in a timely manner. To best accomplish that we ask that you complete the following question and we will do our best to accommodate them in our effort to assure smooth communication.

Would you prefer that we contact you with normal results? Yes_________ No________

Phone number that you would like us to call with you results ______________________________

Would you like us to leave the results on your answering machine? Yes__________ No _________

Is it OK to call you at work? Yes__________ No__________

Home telephone#________________________________ Work #_______________________________ Cell # __________________________________

Would you like us to leave a message with another person? Yes_________ No_________ If yes, with whom? _________________________________

Patient/Parent/Guardian Signature ____ Date________________________________

HERNDON DERMATOLOGY – Anh P. Dang-Vu, M.D., P.C.

PATIENT MEDICAL HISTORY

This form is a part of your permanent medical record. Please complete it as thoroughly as possible

Name: ____Date of Birth: ______________________Age: __________

Date of Visit: ________________

Reason for Visit: ____

Skin check for skin cancer, abnormal moles today? Complete _______Above the waist _________Decline_________

List of Medications:

____

____

____

____

____

____

____

Allergies:

____

Past and Current Medical History:

____

____

____

____

____

____

____

Past Surgical History:

____

____

Family History of non-melanoma or melanoma skin cancers

____

____