V. LIGHTNER FAMILY DERMATOLOGY

82 Wheaton Ave., Youngsville, NC 27596 (919) 562-8887

MINOR PATIENT REGISTRATION FORM

Chart#____________

Child's Name: ______________________________ Today's Date:____/____/____
First Middle Last

Date of Birth:____/____/____ Sex: ☐ M ☐ F SS#____________________

Name You Prefer to be called: ____________________ Who referred you? ____________________

If Student: ☐ Full Time ☐ Part Time Name of School____________________

Home Address: ____
Street# Street Name Apt #

____
City State Zip

Legal Guardian/Parent Name: ______________________________ DOB: ____/____/____
First Middle Init. Last

Home Phone: __________ Work Phone: __________ Cell Phone:__________ Social Security #__________

Address if different from patient's:____
Street City State Zip

================INSURANCE INFORMATION (please fill in all blanks, write none if it doesn't apply)=================

Primary Insurance:

Cardholder's Name:______________________________ DOB:____/____/____

Insurance Company:____________________ Patient relationship to policy holder: ☐ Self ☐ Child ☐ Other__________

Insured's Address if different from above:____
Street City State Zip

Employer: ____
Name Address Phone

Secondary Insurance:

Cardholder's Name:______________________________ DOB:____/____/____

Insurance Company:____________________ Patient relationship to policy holder: ☐ Self ☐ Child ☐ Other__________

Insured's Address if different from above:____
Street City State Zip

Employer: ____
Name Address Phone

Please present insurance card(s) and photo ID to the receptionist so copies may be made.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

(over)

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. We accept assignment on many insurance companies upon verification of benefits. If we are unable to verify coverage at the time of your visit, we reserve the right to request payment in full. Once coverage is verified, you need only pay your deductible and/or copay. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, VISA AND MASTERCARD FOR YOUR CONVENIENCE.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. Because of the complexities of insurance filing, we offer this service as a courtesy to our patients. We are happy to assist you in any way to assure you receive your benefits; however you are ultimately responsible for timely payment of your bill. You will be billed for any unexpected uncovered services after insurance responds. There is a $25.00 charge for returned checks.

Uninsured patients or those filing their own insurance are expected to pay in full at the time services are provided. Again, we accept cash, check, Visa or MasterCard. We do not wish to deny services to patients who are truly unable to pay. If you are having a financial crisis, you must make payment arrangements with our Practice Manager before the doctor treats you.

Your signature below indicates you understand and accept this policy.

AUTHORIZATIONS

☐ **I hereby authorize medical/surgical treatment, care and/or services by Virginia Lightner Family Dermatology, PA to the above named patient.**

☐ **I hereby consent to the use and disclosure of protected health care information of the above named patient for the purposes of treatment, payment and healthcare operations.**

☐ **I hereby authorize payment of medical benefits to Virginia Lightner Family Dermatology, PA when an assigned claim is filed.**

☐ I authorize treatment of my child in my absence in situations where my child may drive himself/herself to their appointment. (Parent/Legal Guardian must be present for **all** Accutane visits.)

☐ I authorize treatment of my child in my absence in situations where my child may be accompanied by another family member/adult. This authorization will be valid for one year from today's date**. The name of the family member/adult who may bring my child and authorize treatment is:**

____

Full Name Address Phone

May we e-mail personal medical information regarding this minor to you? [ ] YES [ ]NO E-mail address:______________________

May we leave personal medical information regarding this minor on your answering machine at home? [ ] YES [ ] NO

Where would you like us to call for appointment reminders? [ ] Home# [ ] Parent's Work# [ ] Parent's Cell#

____________ ____________ ____________

I agree that all of the above authorizations are valid indefinitely.

____ _________________________

Parent/Legal Guardian Signature Date