Appt. Date:____/______/______ Time:____________ Acct. # ______________

CHRISTOPHER R. HUBBELL, M.D.

Patient Registration Form

How did you hear about us?

☐ Yellow Pages ☐ Yellow Book ☐ Bayou Pages ☐ Seminar
☐ Website/Internet ☐ The Independent/FACE/008 Magazine
Friend/Family(Name) ______________ Doctor ______________________
Church Bulletin ______________ Other (Specify) ____________________

Patient Name__________________________________ ☐ Jr. ☐ Sr. *EMAIL ________________________________

Age________________________________ Birthdate ________/________/________ Sex ☐ M ☐ F

Ph:_____/_______-_______ Alt Ph:_____/_______-_______ SSN# ______________________________

Address ____
Street # Street Name Apt. #

____
City State Zip Code

Patient Employer ____ Phone Number _______/________-________

Spouse____ Birthdate__________/______/__________

PATIENT OR GUARDIAN INFORMATION IF PATIENT IS MINOR

____
Name # Street City State Zip Code

Home Phone_________/____________-____________ Work Phone_________/____________-____________

Social Security # __________-____________-____________ Birthdate__________/______/__________

To whom do you give our office permission to discuss your medical and financial information with?

Name:____ ☐ DO NOT GIVE ANYONE MY INFORMATION

Relationship:____ Phone Number:__________/______-__________

Name:____

Relationship:____ Phone Number:_______/______-__________

INSURANCE INFORMATION

Primary Insurance Carrier Name:____

Policyholder Name:__________________________________ Relationship to the Patient__________________

Policyholder Social Security # _______-_______-_______ Policyholder Date of Birthday _______/______/_______

Secondary Insurance Carrier Name:____

Policyholder Name:__________________________________ Relationship to the Patient__________________

Policyholder Social Security # _________-_________-_________ Policyholder Date of Birthday ________/________/________

PLEASE FILL OUT FRONT AND BACK AND BRING WITH YOU ON THE DATE OF APPOINTMENT.
PLEASE PRESENT INSURANCE CARDS & PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.

******PATIENT WITH PRIVATE INSURANCE******

In order to establish optimal relations with our patients and to avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.

Payment in required for all services at the time they are rendered. We accept payment in the form of check, cash, MasterCard, Visa, Discover, or American Express. If you are a member of a medical insurance plan that Acadiana Dermatology, APMC is a provider for, then at the time of service you are responsible for all applicable co-payments and deductibles. For those patient who have chosen a medical insurance plan that we do not have a contractual relationship with (i.e. we are not a provider for your plan), we require payment in full at the time of service, and we do not file your charges but we will give you a fee bill that contains all the necessary codes and information that you can file with your insurance plan for reimbursement. We do make an exception to this rule in the following situation: your charges on a single date are for a surgical procedure that exceeds $500.00 and you have written proof from your insurer that you have met all applicable co-payments and deductibles and you pay at least 35% of the bill at the time of service and finally, that prior authorization from your insurance company has been obtained (when required). Keep in mind that your insurance company's authorization for treatment is not a guarantee that they will pay any portion of your bill. In the event that your insurance fails to pay the bill, you are still completely financially responsible for payment.

Additionally, you hereby acknowledge understanding that you are responsible for all fees including legal or other incurred in the collection of your account should it become delinquent. Acadiana Dermatology/a Jeuné Medical Spa has the right to turn you over to a collection agency in the event your account becomes delinquent.

Your signature below signifies your understanding and willingness to comply with this policy. Further, your signature authorizes this office to release such medical information necessary to process your insurance claim (if any). You herein authorize payment of medical benefits to Acadiana Dermatology/ a Jeuné Medical Spa or to the doctor when the assigned claim is filed.

PATIENT SIGNATURE OR GUARDIAN ________________________________ **DATE** ____________________

******PATIENT WITH MEDICARE******

PAYMENT POLICY:
Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $162.00 deductible and paying for the 20% co-payment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be balanced billed.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE ____ **DATE** ________________________________
SIGNATURE AS IT APPEARS ON MEDICARE CARD

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE ____ **DATE** ________________________________