ROBYN MESSING, DO PLLC

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SS#: _____ **EMPLOYER:** _____

PHONE (H): _____ **PHONE (W):** _____ **PHONE (C):** _____

SEX: Female / Male _____ **MARITAL STATUS:** Single Married Other

Referring Dr.: _____ **Primary Care Dr.:** _____

If patient is under 18 years of age…

RESPONSIBLE PARTY: _____ Date of Birth: _____

ADDRESS: _____ SS#: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE (H): _____ PHONE (W): _____

NAME OF INSURANCE #1 _____

POLICY #/ENROLLEE ID #/SUBSCRIBER #: _____ GROUP #: _____

POLICY HOLDER: _____ PHONE # _____

POLICY HOLDER DOB: _____ POLICY HOLDER SS#: _____

NAME OF INSURANCE #2 _____

POLICY #/ENROLLEE ID #/SUBSCRIBER #: _____ GROUP #: _____

POLICY HOLDER: _____ PHONE # _____

POLICY HOLDER DOB: _____ POLICY HOLDER SS#: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY) in order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Robyn Messing DO PLLC/Billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be directly to Robyn Messing DO PLLC/Billing company. If I have Medicare insurance, I authorize Robyn Messing DO PLLC/Billing company to release to the Social Security and Care Financing Administration or its Intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by mysdf or by Robyn Messing DO PLLC/Billing company by written request.

SIGNATURE: _____ DATE: _____

Revised 2/16/12 DLS

Robyn Messing, DO, PLLC
Practice of Dermatology

Acknowledgment of Receipt of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed or permitted under federal and state law, and outlining my rights regarding my health information.

Signed _____ Date _____

(If not signed by patient)

Patient Name _____ Relationship to Patient _____

The information below will assist us in your care and in any communications with you, while protecting your confidentiality. Please review, circle choices, and fill in any necessary information. You may amend this statement at any time.

YES NO Leave message at my home or cell answering machine regarding appointment scheduling

YES NO Leave message at my home or cell requesting a return call

YES NO Leave message at my office requesting a return call (office # _____)

YES NO Leave a message on my office voice mail regarding my health care

YES NO May speak with _____ regarding my treatment
Name/Phone Number

_____ _____
Signature Date

Welcome to Practice of Dermatology

In order to provide quality care to our patients, improve access to and minimize waiting for appointments, our office has adopted the following policy regarding missed appointments.

I understand that if I should fail to keep scheduled appointment in a twelve (12) month period, it may be necessary for me to make arrangements to receive my medical care elsewhere.

I further understand that the procedure works as follows:

- A telephone call must be made at least 24 hours prior to scheduled appointment to avoid a missed appointment fee.
- If one appointment is missed, a reminder letter will be sent indicating that a scheduled appointment has been missed and depending on your insurance, a new referral maybe required to schedule another appointment.
- If a second appointment is missed a fee will be required before scheduling next appointment or dismissal maybe issued. The current fee for a missed appointment ranges from $50 to $80.

Insurance Billing

Please have all insurance cards and information available each time you check in.
The accompanying parent or guardian of a minor will be responsible for payment of any services rendered in the physician office. Minors not accompanied by a parent or guardian must have a signed authorization form or letter from the parent or guardian.
Our billing office will file your claims promptly to all participating insurance companies. If you have any questions or concerns, please contact our billing office at (517) 676-9788 extension 5. Remember that it is your responsibility to know your insurance coverage and benefits. That information can be obtained by contacting your insurance carrier or employer. *Co-pays must be paid at the time of your appointment.*

Payment at Time of Service

- For office services and/or cosmetic services we request that you pay at the time of service for all non-participating insurance coverage, non-covered services, and all co-payments. We accept VISA and MASTERCARD, as well as cash, check, or money order.
- Remember always that we are here to help you with billing and payment problems. If you have trouble in settling your account with us, please make us aware of it. Any time there is some difficulty, please talk with my staff in person or by phone.

Medication Refills

Please bring your medications with you to every appointment. Requests for prescription refills should be made at your appointments whenever possible.

I understand and agree to the above:

Patient signature:_____ Printed name:_____

Guardian signature:_____ Date:_____

IMPORTANT NOTICE TO ALL PATIENTS

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL INSURANCE POLICY. MANY INSURANCE POLICIES HAVE EXCLUSIONS, AND MOST HAVE DEDUCTIBLES, AND CO-PAYMENTS / CO-INSURANCE. SOME INSURANCE POLICIES MAY NOT COVER OUR SERVICES.

IT IS IMPORTANT FOR YOUT O CHECK WITH YOUR INSURANCE CARRIER TO DETERMINE IF THE PROVIDER YOU ARE SEEING IS LISTED AS AN “IN-NETWORK” PROVIDER. IF THEY ARE NOT LISTED AS AN “IN-NETWORK” PROVIDER YOU MAY HAVE A HIGHER DEDUCTIBLE AND OR CO-PAY.

REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR ALL BILLS NOT COVERED BY YOUR INSURANCE POLICY.

_____ _____

Signature of Patient/Guardian Date