

NaperBrook Dermatology

550 E. Boughton Rd. Suite 170, Bolingbrook IL 60440

Phone: 630-739-DERM(3376) Fax: 630-739-3377

Patient Name: _____

Referred by: Physician's Name: _____ Physician's Number: _____
 Insurance Friend/Relative Web Other: _____

Mailing Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Ext:** _____ **Marital Status:** _____

Social Security Number: _____ **D.O.B:** _____

Primary Insurance: _____

Insurance Address: _____

Insured Name: _____ Relation to Patient: _____ D.O.B: _____

Subscriber ID: _____ Group Number: _____ SSN: _____

Secondary Insurance: _____

Insurance Address: _____

Insured Name: _____ Relation to Patient: _____ D.O.B: _____

Subscriber ID: _____ Group Number: _____ SSN: _____

Insured Party's Employer Name: _____ **Work Phone:** _____

Employer's Address: _____

Emergency Contact Name: _____ **Relation to Patient:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Pharmacy Name: _____ **Pharmacy Number:** _____

Insurance Authorization and Assignment

I hereby authorize NaperBrook Dermatology (also known as Bharati Chittineni, M.D. S.C.) to furnish information to my insurance carriers concerning my diagnosis and treatments, and I assign to NaperBrook Dermatology all payments due for services rendered to myself or my dependents if I do not make payments in full for such services.

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a picture id. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your physician.

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I understand that I am responsible for any amount not covered by my insurance and agree to tender payment within **30** days of notification by statement of this responsibility and that failure to do so may incur additional billing charges. If an account is overdue longer than **90** days, it will be referred to a collection agency. This is a last resort, done reluctantly and after we have exhausted efforts for voluntary payment. In the event that any action is brought to collection, I agree to pay **100%** of the fee for collection costs/and or any reasonable attorney fees. A charge of **\$25** will be added to your account for any check returned by your bank for insufficient funds. Missed or cancelled appointments with less than **24 hours** notice to our office are subject to a **\$25** no call no show fee.

I further understand that a photocopy of this authorization shall be as valid as the original.

(Date) (Print Name of Patient) (Signature of Patient or Guardian)

Minor Patient Guarantor Agreement

Minor Patient Name: _____

I agree upon notification by statement to be responsible for prompt payment of the balance due on the account of the aforementioned minor child, if the designated responsible party does not fulfill his/her responsibility within 30 days of the date(s) of service.

(Date) (Print Signature Name) (Signature of Patient or Guardian)

Medical Services Release

I have been informed and understand that services to be provided today may be denied by Medicare Part B or any other insurance carriers by deeming them one or more of the following:

- (1) Medically Unnecessary (2) Due to a Pre-Existing Condition (3) Cosmetic Purposes

I feel that these services are necessary. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment to NaperBrook Dermatology (aka Bharati Chittineni, M.D., S.C.)

(Date of Service) (Patient or Guardian Signature) (Date of Service) (Patient or Guardian Signature)

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Acknowledgement of Receipt of HIPPA Privacy Policies

Under the Federal HIPPA laws we are mandated to provide our patients with a copy of our Patient Privacy Policies. Your signature is your acknowledgement that you have either received a copy today, have been offered a copy today or have downloaded it from our website at www.naperbrookdermatology.com

Date: _____ Print Patient Name: _____

Patient or Guardian Signature: _____