Northstar Dermatology, P.A.
5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-DERM (3376)
Fax: 817-427-3379

Patient Registration

Name: _____

Address: _____

City, State, Zip: _____

Date of birth: _____ Age: _____ Sex: _____ Social Security: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Drivers License: _____ Employer: _____

Referring Physician: _____

City, State, Phone # (of referring physician): _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

How did you hear about us: ☐ Friend/Family Member ☐ Insurance Company ☐ ZocDoc ☐ Postcard
☐ Physician Referral ☐ Walk-in ☐ Website ☐ Yellow Pages ☐ Other: _____

Parent / Guardian Information (Responsible Party)

Name: _____

Address: _____

City, State, Zip: _____

Date of birth: _____ Age: _____ Sex: _____ Social Security: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Drivers License: _____ Employer: _____

Consent for Examination, Treatment and Financial Responsibility Agreement

I hereby consent to and authorize the physician and employees to provide medical care to the patient identified above. If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up-to-date insurance information prior to treatment. I also acknowledge that the filing of an insurance claim(s) is NOT A GUARANTEE OF PAYMENT, and that I AM FINANCIALLY RESPONSIBLE FOR PAYMENT if such claim(s) are unpaid or denied by the insurance company. I authorize payment of medical benefits directly to the doctor for service(s) provided to me. I understand I am ultimately responsible for payment of services rendered. I am at least 18 years of age, or if not, I am accompanied by a legal guardian. Delinquent accounts are subject to a finance charge, collection fees, and reasonable attorney fees.

I authorize Northstar Dermatology to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

Signature of Patient or Guardian: _____ **Date:** _____

Northstar Dermatology, P.A.
5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

Privacy Policy

Our "Notice of Privacy Practices" provides information about how Northstar Dermatology may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. The Notice is available to you on our website at www.northstardermatology.com and at the front desk at your request. You may review the Notice before signing this consent. As a patient, you have the right to request restrictions on use and disclosure of your health information.

With your consent, Northstar Dermatology may call, mail, or email to your home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, insurance items, and/or any information pertaining to your clinical care. By signing this form, you consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your Health Insurance Company, and overall health care operations.

If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Telephone Communication: Please indicate if you would like for us to leave information regarding your care on your voicemail. Please initial by the option of your choice and include a designated phone number if you would like for us to leave a detailed message regarding your healthcare, including lab or pathology results.
_____ Leave a message with detailed information about my healthcare. Phone Number: _____
_____ Leave a message with call-back number only.

Persons Authorized to Receive Information About Your Care:
I authorize Northstar Dermatology to release medical, appointment, and/or financial information over the telephone or in person to the following person(s) (i.e. spouse, family member, etc.):

1. _____
   Name Relationship Telephone Number

2. _____
   Name Relationship Telephone Number

Signature of Patient or Legal Representative: _____ Date: _____

Name of Patient or Legal Representative: _____
(If Guardian or Legal Representative, please include relationship to patient)

Consent for Examination, Treatment and Financial Responsibility Agreement

I hereby consent to and authorize the physician(s) and employees at Northstar Dermatology to render care to me during my office visit(s). In consideration of services rendered or to be rendered, I assign and transfer to Northstar Dermatology any benefits payable to me or on my behalf under any insurance coverage or Medicare. I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up-to-date insurance information prior to treatment. I understand that I am financially responsible for services provided which are to be paid on the date of service. This includes copayments, deductibles and/or coinsurance with any managed care contract. I also acknowledge that the filing of an insurance claim(s) is not a guarantee of payment, and that I am financially responsible for payment if such claim(s) are unpaid or denied by the insurance company.

I authorize the release of my medical information to my primary care physician, referring physician, and/or consultants as necessary to carry out treatment and to process insurance claims and/or prescriptions. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize taking photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

Signature of Patient or Legal Representative: _____ Date: _____

Name of Patient or Legal Representative: _____
(If Guardian or Legal Representative, please include relationship to patient)