

# DERMATOLOGY CENTERS OF NEPA

Christopher A. Snyder, D.O.

Referred by:  Physician: \_\_\_\_\_  Friend  Phonebook  Newspaper  Sign  Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Street City State Zip

Please Check One:  Male  Female Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Telephone #: \_\_\_\_\_ May we leave a message on this number  Yes  No

Cell#: \_\_\_\_\_ May we leave a message on this number  Yes  No

Work #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

If under 18: Mother's/Father's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pharmacy (where you get your prescriptions filled): \_\_\_\_\_ Location of Pharmacy: \_\_\_\_\_  
May we obtain your medication history  Yes  No

Name of Family Physician/Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## INSURANCE:

Primary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Full Name (The person who holds the policy) \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

- Notice of Privacy Practice Patient Acknowledgement:

I have received and/or reviewed this patient's Notice of Privacy Practices. The notice provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

- Release of Information:

Your doctor is not allowed to release information to anyone but the patient. If you would like our office to be able to discuss results with anyone besides yourself, please indicate this below:

Only to myself

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_

By signing below I acknowledge that I have read and understand the above information. Please feel free to ask any questions.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(If you are younger than 18 years old, forms must be signed by a parent or guardian)

DERMATOLOGY CENTERS OF NEPA

Christopher A. Snyder, D.O.

I the undersigned hereby grant permission to release my medical information and medical records and authorize payment of benefits to: **Christopher A. Snyder, D.O. Corporation**. I also understand that I am fully responsible for payment of **deductibles and co-payments** and of any charges that are incurred and not covered by my insurance. **Medicare Patients:** "I request that payment of authorized Medicare benefits be made to either me, or on my behalf to **Christopher A. Snyder, D.O. Corporation** for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits and payment for related services".

**SHOULD THIS ACCOUNT GO TO COLLECTIONS FOR NON-PAYMENT, THE PATIENT/GUARANTOR ACCEPTS RESPONSIBILITY FOR ALL COLLECTION/ATTORNEY FEES.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

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Because we are extremely busy, we will be charging \$25.00 for any missed appointments. While this may seem extreme, there is a waiting list/cancellation list for appointments. These appointments would have been filled by someone who needs them.

Co-pays must be paid at the time of service prior to seeing the provider. If you do not have your co-pay your visit will need to be rescheduled