Bala Dermatology
William K. Sherwin, M.D., Ph.D.
Mary E. Griffin, D.O. FAAD

NEW PATIENTS/INSURANCE CHANGES

One Bala Plaza● Suite 620, Bala Cynwyd, PA 19004
www.baladermatology.com●Phone: 610.664.3300 ●Fax: 610.664.1151

PATIENT INFORMATION

Name: (Mr., Mrs., Ms., Miss., Dr.) _____

DOB: _____ **Sex**: _____ **Marital Status**: _____ **SSN:** _____

Occupation: _____ **Student:**_____ Full or Part-time(Circle)

For Patients under 18 years old ONLY:

Parent/Guardian Name_____

Address(only if different from patient)_____

Primary Care Physician: _____

Phone number: _____ Fax Number: _____

Address: _____

How did you learn about our office(Who referred you)? _____

Primary Insurance Information:

Insurance company: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber: Self __ Spouse __ Dependent__ SSN: _____

Policy #: _____ Group #: _____

Secondary Insurance Information:

Insurance company: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber: Self __ Spouse __ Dependent__

Policy #: _____ Group #: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Address: _____

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PAYMENT AGREEMENT

I request that payment of authorized benefits be made to Bala Dermatology for any services provided. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

My name below verifies the accuracy of all of the above information including address, phone number, and medical history.

Patient or Authorized Designee Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I have been given an opportunity to read the Notice.

I hereby authorize Bala Dermatology to obtain, use and disclose private health information about me to carry out treatment, healthcare operations and to secure payment from my insurance carrier (including Medicare, Blue Shield, Personal Choice, Aetna, Major Medical and all other private insurance carriers). I have the right to review the Notice of Practices prior to signing this consent. Further, I authorize my insurance carrier to make direct payment to Bala Dermatology. I realize I am responsible for deductibles and copayments not covered by private insurance companies.

Signature _____ Date _____

Signature of Authorized Representative _____