Bala Dermatology

NEW PATIENTS/INSURANCE CHANGES

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

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)

Email: ____

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)? ______________________________

Pharmacy Name: ____

Address: ____

Phone Number: ____

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: _______________

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

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

Address: ____

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 ____