REGISTRATION INFORMATION Date:_____

Phone #:_____ Cell #_____

Patient (last name) _____ (first name)_____

Address: _____Apt#_____

City:_____ State:_____ Zip Code: _____

Email address_____

Patient's birth-date:_____ Age:_____ Male__ Female__Patient's SS#_____

Single____ Married ____Widowed____ Divorced ____ Separated ____ Domestic Partner____

Patient employed by:_____ Work Phone #:_____

Who is responsible for this account?_____

Birthdate of person responsible_____Relationship to patient: _____

Do you have medical insurance? Yes____ No____ If Yes:
Name of primary insurance company:_____

Identification #:_____ Group #:_____

Name of secondary insurance (if any):_____

Identification #:_____ Group #:_____

In case of emergency, notify _____

Relationship to patient:_____ Telephone #:_____

How did you hear about Skinworks PLLC/ Javier Zelaya MD PC
Magazine ad (which one)_____TV ad_____ Movie theater_____
Insurance Directory_____ Internet Search ___Physician___Friends/family_____ other_____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed under federal and state law. I understand the contents of the Notice, and I request the following restriction concerning the use of personal information:

_____

_____

Furthermore, I permit a copy of this information to be used in the place of the original, and request payment of medical insurance benefits to the physician. Regulations pertaining to medical assignment of benefits apply.

Payment Policy Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any **applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by insurance company. Prior authorization does not guarantee payment of claims. If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it, it may be necessary to reschedule your appointment. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure.

A $25.00 "No Show" fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment. A fee will be charged for any returned checks.

Your signature below signifies your understanding and willingness to comply with these policies.

I have read the Payment Policy and Insurance coverage described above. I understand and agree to all its provisions.

Patient Signature: _____Date _____

If patient is a minor or is incompetent to give consent please sign below and indicate relationship to patient