



REBECCA T. SATOSKAR, MD

INTEGRATED DERMATOLOGY OF FAIRFAX

REGISTRATION INFORMATION

PATIENT INFORMATION					DATE:	
LAST NAME		FIRST NAME	MI	BIRTHDATE		SOCIAL SECURITY #
HOME ADDRESS			CITY	STATE	ZIP	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SPOUSE'S NAME		HOME #		WORK #		
EMAIL ADDRESS		MOBILE #		MARTIAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE		
RESPONSIBLE PARTY INFORMATION (If other than self)					<input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPERATED <input type="checkbox"/> WIDOWED	
LAST NAME		FIRST NAME	MI	HOME #		
ADDRESS			CITY	STATE	ZIP	SOCIAL SECURITY #
EMPLOYER			OCCUPATION		WORK #	
EMPLOYER'S ADDRESS			CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
MOTHER'S NAME		MOTHER'S BIRTDATE	FATHER'S NAME			FATHER'S BIRTHDATE
EMPLOYMENT INFORMATION						
PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT			OCCUPATION		EMPLOYMENT OR STUDENT STATUS:	
PATIENT'S EMPLOYER OR SCHOOL ADDRESS			<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> SELF EMPLOYED			
CITY			STATE	ZIP	<input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> ACTIVE MILITARY <input type="checkbox"/> RETIRED	
EMERGENCY INFORMATION						
NAME			RELATIONSHIP			HOME #
ADDRESS			CITY	STATE	ZIP	WORK #
INSURANCE INFORMATION <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> MEDICARE <input type="checkbox"/> HMO CO-PAY \$						
PRIMARY INSURANCE		SOCIAL SECURITY #		CARDHOLDER		DATE OF BIRTH
GROUP NUMBER			IDENTIFICATION NUMBER			EFFECTIVE DATE
ADDRESS			CITY	STATE	ZIP	PHONE NUMBER
SECONDARY INSURANCE			CARDHOLDER			DATE OF BIRTH
GROUP NUMBER			IDENTIFICATION NUMBER			EFFECTIVE DATE
ADDRESS			CITY	STATE	ZIP	PHONE NUMBER
PHARMACY INFORMATION -Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.						
PHARMACY NAME			PHARMACY PHONE NUMBER			
ADDRESS			CITY	STATE	ZIP	

Rebecca T. Satoskar, MD
Urvi P. Gonzales, MD
Kelley P. Redbord, MD
Samantha Wasielewski, PA



ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of Fairfax, LLC of any medical benefits payable to me for the services provided at Integrated Dermatology of Fairfax, LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

Please be aware our office is not liable for any lab bills. It is patient responsibility to inform our office of which lab your insurance company has a contract with.

FEES

I also understand that if I do not cancel my appointment within 24 hours of my appointment time, I am subject to a \$100.00 fee for exam visits and \$150.00 fee for surgical or cosmetic visits.

X _____
Patient Signature or Signature of Guardian or Parent Date

MEDICARE PATIENTS ONLY - Lifetime Signature on File and Lifetime Consent

I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of Fairfax, LLC. 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 those benefits or the benefits payable for related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology of Fairfax, LLC. 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 or the benefits payable for related services.

X _____
Signature of Beneficiary Medigap Insurer Medigap # Date