RENUKA DIWAN, MD
REGISTRATION FORM

Name_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone (____) _____ Work Phone (___) _____

Cell Phone (_____) _____ Driver's License # _____
(REQUIRED)

Date of Birth _____ Age_____ Sex_____ SS#_____

Can we leave messages on an answering machine? ___Yes ___ No
Preferred mode of contact? ___Home ___Cell
Lab results may be relayed to: Myself ___ Spouse ___ other _____

Due to privacy laws. We are required to verify your identity when you receive a call from a member of our staff to notify you of test results. You will be asked for your driver's license number for this purpose.

We occasionally offer promotions on cosmetic services and free skin cancer screenings. If you would like to be notified of promotions and events **please "like" us on Facebook.** You can also access your medical records electronically. If you are interested in doing so, please provide your email address and add lassc@sbcglobal.net to your "accept" list.
Your email address_____

*Ethnicity: Hispanic or Latino____ Not Hispanic or Latino____Prefer not to answer____
*Race: White_____ Other (please specify) _____
*Preferred language spoken at home_____
*Required by Affordable Healthcare Act

Occupation:_____ Level of Education: _____
Employer: _____
Employer's Phone Number: _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed_____
Spouse/Partner's Last Name: _____First Name: _____
Mother's Maiden Name: _____
Referred By: _____

Primary Care Physician: _____ Phone Number: _____
Address: _____

Preferred Pharmacy: _____ Phone Number: _____
Address: _____

CONTINUED ON BACK

EMERGENCY CONTACT---**REQUIRED**

Name (**OTHER THAN YOURSELF**) _____
Home Phone ( ) _____Work Phone ( ) _____
Cell (___) _____
Relationship to patient? _____
Address same as Patient? ___yes ___no

Do you have a living will/advance health care directive? _____
If yes, please give us information necessary for your care in case of emergency._____
_____

PRIMARY INSURANCE

Insured's Name_____ Relation to Patient_____

Insured's SS# _____Insured's Date of Birth _____

Insurance Company Name_____

Policy/ID# _____ Group Number _____

SECONDARY INSURANCE

Insured's Name_____ Relation to Patient_____

Insured's SS#_____ Insured's Date of Birth _____

Insurance Company Name_____

Policy/ID# _____ Group Number _____

Do you have coverage through a Group Health Plan through your current or former employer, of the current or former employer of a spouse or family member? If so, how many employees work for the employer providing coverage?
More than 20? ___yes ___no More than 100? ___yes ___no

Do you currently have COBRA? _____

Are you in Hospice? _____

PAYMENT POLICY: Due to greater costs incurred by seeing an out-of-network physician, it is your responsibility to confirm that Dr. Diwan is an in-network physician for your health plan, with your insurance company. For your convenience, our office will file claims with your insurance company for covered services. Payment for any services that are not paid by your insurance company are your responsibility. **Office co-pays and deductibles are due at the time of the visit.** If your insurance requires you to have a referral for seeing a specialist, please obtain a referral from your primary care doctor prior to your appointment with Dr. Diwan. Failure to do so will result in lack of insurance coverage and you will be responsible for our charges. There is a $10.00 fee for completion of any additional insurance forms that you wish to submit. There will be a $50.00 charge if you do not show for an appointment without notification 48 hours in advance. There will be a $100.00 no-show charge incurred for a laser treatment and a $600.00 charge for a missed Sculptra appointment.

I UNDERSTAND that there is a $25.00 charge for **returned checks**.

Payment for **services not covered by insurance** is required at the time of your visit. You will be asked to sign an Advanced Beneficiary Notice form for services that we believe will not be covered by Medicare, if applicable.

I AGREE that in the event my account is turned over to a collection agency or an attorney, for collection of unpaid balances, I will be responsible for all **additional costs** incurred in the collection of my debt.

I authorize the **release of medical information**, including pathology slides, necessary for treatment and to process this claim, and also authorize payment of medical benefits to the physician.

Please refrain from bringing young children to your appointment. Interruptions due to a child's needs distract from consultations and procedures. Our staff cannot provide supervision for children. Please find child care outside our office. Our experience over the years necessitates this policy and we appreciate your cooperation. Our office is in a pet-free building. Please leave your pet at home (with the exception of a seeing-eye dog).

Signature _____ Date _____