



Robert K.P. Chow, M.D.

DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY

Medical and Aesthetic Dermatology, Surgery, and Phototherapy

Personal Information

Last Name		First Name	M.I.
Person responsible for paying bill if not patient:			
Address:			
City		State	Zip
Email (optional)		Spouses's Name/Parent if Minor	
Home Phone		Patient Work Phone	Cellular Phone
Date of Birth	Gender	Social Security Number (required)	Marital Status
Patient Employer (or student status)		Copy of Driver's License (required)	

Insurance Information (required)

	Primary Insurance	Secondary Insurance
Insurance Name Through Employer? Y N		
Subscriber's Name Same address as above? Y N		
Subscriber's Social Security No.		
Subscriber's Birth Date and Sex: M or F		
Relation to Subscriber: Child, Spouse, Self, Other		
Policy Number		
Group, Member or Claim No.		
Effective Date		
Co-payment amount may not be printed on card. Contact your insurance to confirm.		

Referral Information

How did you hear about us? (please circle) Doctor Friend Family Yellow Pages Internet

Is your insurance a managed care plan that requires a referral/authorization from your primary care doctor? Yes No

If yes, upon arrival, please confirm with the receptionist that a referral/authorization is on file for your visit.

Who is your primary care doctor? _____ Office Phone: (____) _____

Referred to this office by: _____

Emergency contact (someone not currently living with you)

Name	Relationship	Phone Number
_____	_____	() _____

Additional Services

Would you be interested in a complimentary skincare consultation with our esthetician? Yes No

Would you like to discuss any cosmetic procedures or services with the doctor? Yes No

(Please circle all that apply.)

Botox	Laser
Restylane & other fillers	Microdermabrasion
Chemical Peels	Hair Removal

Patient Authorizations & Notice of Privacy Practices

Do we have permission to leave a message on your home answering machine? Yes No

Do we have permission to leave a message at your place of employment? Yes No

I give permission to discuss my medical condition/information or billing with the following people:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I have received a copy of Dr. Chow's Notice of Privacy Practices Yes No

If no, reason: _____

I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance coverage is **NOT** a guarantee of payment for services provided by my healthcare provider including preventive, routine screening, or procedures considered cosmetic in nature. **It is my responsibility to understand my insurance benefits.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. **Co-payments mandated by my insurance company may not be printed on my insurance card. I understand the Co-payments are due at the time of service.** It is my responsibility to notify the receptionist upon arrival that a co-payment is due. A **\$20.00** handling fee will be added to my statement in circumstances when I have not paid at the time of service. I have been informed that NSF's for checks or credit card payments are subject to a **\$30.00** handling fee for each submission. I have been informed that payment is due upon the receipt of my monthly statement. Should I have **NO** insurance I understand that payment is due in full at the time of service.

Patient Signature

Date