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 bill if not patient

Address

City	State	Zip

E-mail (optional):	Spouse's Name/Parent if Minor:

Home Phone ( )	Work Phone ( ) Ext.	Cellular Phone ( )

Date of Birth	Gender M F	Social Security Number (req.)	Marital Status

Employer (or student status)	Copy of Driver's License (required) ❑

Insurance Information

Primary Insurance Group/ID No.	Secondary Insurance Group/ID No.	Notes:

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 ( )

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 and understand the terms. ❑ Yes ❑ No

If no, reason: _____

I have received a copy of Dr. Chow's Financial Policy and understand the terms. ❑ 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