Duke Lightner Dermatology, CPDC
Minor Registration Form

Patient Label Here

Minor's Full Legal Name:_____ Today's Date____/____/____

Address:_____ Name child prefers to be called:_____

_____ Sex: [ ] M [ ] F Date of Birth:____/____/____

City, State, Zip:_____ Name of School: _____

Home Phone:_____ Social Security#:_____

Primary Physician:_____ Referring Physician:_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other _____

Ethnicity: ☐ I am Hispanic/Latino ☐ I am not Hispanic/Latino ☐ Unknown/Decline to Answer

Preferred language: ☐ English ☐ Spanish ☐ Other _____

Legal Guardian/Parent Name: _____ DOB: ____/____/____
First Middle Init. Last

Social Security #_____ Work Phone: _____

Home Phone: _____ Cell Phone:_____

Address if different from minor's:_____
Street City State Zip

INSURANCE INFORMATION (please fill in all blanks, write none if it doesn't apply)

Primary Insurance:

Cardholder's Name:_____ DOB:____/____/____

Insurance Company:_____ Patient relationship to policy holder: ☐ Self ☐ Child ☐ Other_____

Insured's Address if different from above:_____
Street City State Zip

Employer: _____
Name Address Phone

Secondary Insurance:

Cardholder's Name:_____ DOB:____/____/____

Insurance Company:_____ Patient relationship to policy holder: ☐ Self ☐ Child ☐ Other_____

Insured's Address if different from above:_____
Street City State Zip

Employer: _____
Name Address Phone

(continue on other side)

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. We accept assignment on many insurance companies upon verification of benefits. If we are unable to verify coverage at the time of your visit, we reserve the right to request payment in full. Once coverage is verified, you are required to pay your deductible, co-insurance and/or copay. PAYMENT IS EXPECTED FROM YOU, **AT THE TIME OF SERVICE**, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK AND MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. Because of the complexities of insurance filing, we offer this service as a courtesy to our patients. We are happy to assist you in any way to assure you receive your benefits; however you are ultimately responsible for timely payment of your bill. You will be billed for any unexpected uncovered services after insurance responds.

Uninsured patients or those filing their own insurance are expected to pay in full at the time services are provided. Again, we accept cash, check, and most major credit cards. We do not wish to deny services to patients who are truly unable to pay. If you are having a financial crisis, you must make payment arrangements with our Financial Care Counselor before the doctor treats you.

Duke Lightner Dermatology charges a **no show fee** of $56.00 for any appointment that in not kept or canceled in advance. If you have extenuating circumstances that cause you to miss an appointment, please contact our office as soon as possible after the appointment.

AUTHORIZATIONS

☐ I authorize treatment of my child in my absence in situations where my child may drive himself/herself to their appointment. (Parent/Legal Guardian must be present for **all** Accutane visits.)

☐ I authorize treatment of my child in my absence in situations where my child may be accompanied by another family member/adult. This authorization will be valid for one year from today's date**. The name of the family member/adult who may bring my child and authorize treatment is:**

_____

Full Name Address Phone

Do you have a Duke MyChart account? [ ] yes [ ] no

Do you have proxy access to a Duke MyChart account for this patient? [ ] yes [ ] no
If not, we can help you sign up. Please provide your email address: _____

May we leave personal medical information regarding this patient on your answering machine/voice mail? [ ] yes [ ] no

How would you like us to contact you for appointment reminders for this patient?
[ ] Home# [ ] Work# [ ] Cell# [ ] email [ ]MyChart

I agree that all of the above authorizations are valid indefinitely.

Your signature below indicates you understand and accept these policies.

_____ _____

Parent/Legal Guardian Signature Date