REGISTRATION INFORMATION

DENNIS R. BASSETTI, MD & ASSOC. & Heartland Skin Center. LLC

Name (Last, First, MI)	Social Security Number	Date of Birth	Sex
Street Address	**City, State, Zip**	**Daytime Phone Number**	**Alternate Phone Number**
E-mail Address	**Primary Employer**	**Employer Address**	**Employer Phone Number**

Responsible Party Information:

Name of Insurance Company	Name of Insured	Address of Company	Phone Number of Company	Policy #	Group #	Relationship to Patient

Please state your reason for today's visit?

Who is your primary care physician (PCP)? _____

Who referred you to Heartland Skin Center / Bassetti & Associates, MD, PA?
_____

Please list any medications to which you have an allergy and the reaction caused by that medication.

Drug	Reaction

Patient/Authorized Representative Signature: _____Date: _____

Please list all of the medications that you are currently taking. Please include herbal and over the counter therapies.

Drug Name	Dose	Frequency

Patient/Authorized Representative Signature: _____Date: _____

Consent to Evaluation and/or Treatment: The undersigned hereby consents to whatever evaluation and/or treatment the assigned healthcare provider may deem necessary to the patient named above.
Patient/Authorized Representative Initials: _____

Insurance Assignment: I hereby authorize my insurance benefits to be paid directly to Bassetti & Associates, MD, PA. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered.
Patient/Authorized Representative Initials: _____

For Medicare Patients Only – Medicare Part B Signature Authorization – Lifetime: I certify that the information given by me applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical and other information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for Medicare for payment to me.
Patient/Authorized Representative Initials: _____

Advanced Directive: I understand that the terms of any Advanced Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. Please check one of the following statements:

☐ **I HAVE** executed an Advanced Directive (Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate)(please provide the office with a copy)

☐ **I HAVE NOT** executed an Advanced Directive or I am unable to provide a copy today.
Patient/Authorized Representative Initials: _____

Acknowledgement of Receipt of Privacy Notice/HIPAA Notice: By signing this Written Acknowledgement from Bassetti & Associates, MD, PA / Heartland Skin Center, LLC I hereby expressly acknowledge my receipt of Patient Privacy Practices/HIPAA Notice.

Patient/Authorized Representative Signature: _____ **Date:** _____

Acknowledgment of Receipt of Bassetti & Associates financial policy form: By signing and initialing you agree You have received and reviewed our financial policy Form.
Patient/Authorized Representative Initials: _____

Authorization to Release Medical Information: We understand there are times when you may want a **family member or friend** to act as our representative for things such as picking up prescriptions, making or canceling appointments and speaking with our staff or physicians. Please help us protect your privacy by providing their names and phone numbers below.

Bassetti & Associates, MD, PA and or Heartland Skin Center, LLC may release medical information to (please list name and phone number):

1. _____ 3. _____

2. _____ 4._____

Patient/Authorized Representative Signature: _____**Date:** _____