Renew Dermatology
1603 Santa Rosa Road, Suite 203
Richmond, Virginia 23229

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Sex:**
Address Two:	**Marital Status:**
City:	**Email address:**
State: Zip Code:	**Contact via email?:**
Home Phone #:	**Emergency Contact:**
Work Phone #:	**Emergency Phone #:**
Cell Phone #:	**Emergency Relationship:**
Referring Doctor:	**Primary Care Doctor:**

RESPONSIBLE PARTY INFORMATION

Name:	**Home Phone #:**
Address One:	**Work Phone #:**
Address Two:	**Cell Phone #:**
City:	**Date of Birth:**
State: Zip Code:	**Sex:**

INSURANCE INFORMATION

Primary Ins:	**Second Ins:**
Policy#:	**Certificate#:**
Group #:	**Group #:**
Group Name:	**Group Name:**
Subscr Name:	**Subscr Name:**
Subsc Date of Birth:	**Subsc Date of Birth:**
Relationship to Subsc:	**Relationship to Subsc:**

I authorize Renew Dermatology to release any medical information to my primary care/referring physician, consultants and insurance companies as necessary for the course of my treatment and to process any claims. I hereby assign payment of benefits to Renew Dermatology. I understand that I am financially responsible for all services rendered and for the following reasons: 1) I do not have the proper referral at the time of service 2) my referral is invalid or expired 3) I have given incorrect/invalid insurance information 4) expenses are not covered by my insurance company 5) services rendered are deemed medically unnecessary by my insurance company 6) I have not met my deductible. Payment is required for all services at the time they are rendered including co-payments, non-covered services and any outstanding balances. Balances not paid within 90 days will be turned over to a collections agency and the patient will be dismissed from the practice.

I acknowledge that I have read and agree to abide by the Treatment and Financial Policies of Renew Dermatology. ________(initial)

Your signature below signifies your understanding and willingness to comply with the policies of this office and that the above information is true to the best of my knowledge.

______________________________________ ____________________
Signature (Patient or Guardian if a minor) Date