**SUSAN T. ELLIOTT, M.D**.
Foxhall Dermatology
4910 Massachusetts Ave. N.W., Suite #308
Washington, D.C. 20016-4382

# PATIENT REGISTRATION

Patient Name_____ Date _____

Address_____

City_____ State____ Zip_____ E-mail_____

Phone(H)_____ (C)_____ (W)_____

Date of Birth_____ Age ___Sex ___Marital Status ___ Ethnicity_____ SS#____-___-____

Person Responsible for Payment_____

Address (If Different)_____

City _____ State _____ Zip_____ (Phone)_____

**Pharmacy Name**_____ Location_____
Phone_____ Fax_____

Language spoken_____ Referring Physician_____

How did you hear about **FOXHALL DERMATOLOGY**? Friend___ Internet___ Doctor___Ad___

**PRIMARY INSURANCE**

Name_____

Address_____

City_____State ___Zip_____

Subscriber's Name_____

Subscriber's DOB_____

ID #_____ Group # _____

**SECONDARY INSURANCE**

Name_____

Address_____

City_____State___ Zip _____

Subscriber's Name _____

Subscriber's DOB _____

ID #_____ Group_____

## FINANCIAL AGREEMENT

I understand that Dr. Elliott participates with several insurance companies and hereby assign any or all insurance benefits due and payable from my participating company to her. I authorize the insurance company to pay benefits directly to the physician. Further, I authorize the treating physician to release to my insurance company any medical records or documents required to process a claim. If benefits are denied because my coverage has lapsed or authorizations have not been supplied, I acknowledge that I will be responsible, in full, for services rendered to me, my spouse and my children. Furthermore, I acknowledge that if a deductible or co-payment is included in my plan, I will be responsible for that amount. In the case that this account should become delinquent and is placed in the hands of an attorney for collection, **I agree to pay attorney fees of 33 1/3 % of the principal, plus all court costs and interest at the rate of 1.5% per month (18% per annum), beginning 30 days after the monies were due or expenses incurred**. I further agree to pay returned check charges of **$25** per check. I acknowledge that payment is expected when services are rendered if I belong to an insurance carrier with which Dr. Elliott does not participate. I understand and personally guarantee to be financially responsible to Dr. Elliott for any and all charges not covered by the assignment of the insurance payment.

Signature _____Date _____