Larry E. Urry, M.D.
Allyx Bowthorpe, APRN
Tyler Newman, PA

DR MD
LARRY E. URRY, M.D. THE ART & SCIENCE OF SKINCARE

Washington Terrace
Brigham City
1-800-SKINCARE

Patient Registration Form

Please Print ***All information must be completed***

Patient Information

Today's Date	Last Name:		First Name:	Middle Initial:
Date of Birth: / /	Age:	Ethnicity: `	Marital Status:	Social Security Number:
Street Address (including City, State and Zip Code)			E-mail Address:	
Telephone Number: Home:	Work:		Cell:	
Employer or School Name and Address:				
Primary Care Physician Name:			Specialty: (i.e., Internal Medicine, Family Practice, OB/GYN, Pediatrics)	
Primary Care Physician's Address including City, State and Zip:				

Parent or Responsible Party (*if different from patient)*

Last Name:	First Name and Middle Initial:			
Date of Birth: / /	Age	Sex	Marital Status:	Social Security Number:
Street Address (including City, State and Zip)			E-Mail Address:	
Telephone Number: Which phone number is your preferred method of contact: Home ☐ Work ☐ Cell ☐ Home:	Work:		Cell:	
Employer's Name and Address:			Employer Telephone Number:	

Primary Insurance Information

Name of Insured: (Last, First, Middle)			Social Security Number:
Insured's Address, City, State and Zip Code:			
Telephone Number: Which phone number is your preferred method of contact: Home ☐ Work ☐ Cell ☐ Home:	Work:	Cell:	
Insured's Date of Birth / /	Age	Sex	Marital Status:
Primary Insured's Employer's Name:			Employer's Telephone Number:
Primary Insured's Employer Address (City, State and Zip)			
Name of Insurance			
Insurance Address for Medical Claims: (Street or Post Office Box, City, State and Zip Code)			
Policy No.:		Group No.	
Is prior authorization needed for a visit to a specialist? Yes ☐ No ☐ If yes, Prior Authorization Reference/Tracking No.: _____			

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Secondary Insurance Information (If Not Applicable, Leave Blank)

Name of Insured: (Last, First, Middle)			Social Security Number:
Insured's Address, City, State and Zip Code:			
Telephone Number: Which phone number is your preferred method of contact: Home ☐ Work ☐ Cell ☐ Home: Work: Cell:			
Insured's Date of Birth / /	Age:	Sex:	Marital Status:
Insured's Employer's Name (If applicable)		Employer's Telephone No.: ( )	
Secondary Insured's Employer Address (City, State and Zip)			
Name of Insurance:			
Secondary Insurance Address for Medical Claims: (Street or Post Office Box, City, State and Zip Code)			
Policy No.:	Group No.:		
Is prior authorization needed for a visit to a specialist? Yes ☐ No ☐ If yes, Prior Authorization Reference/Tracking No.: _____			

Tertiary (Third) Insurance Information (If Not Applicable, Leave Blank)

Name of Insured: (Last, First, Middle)			Social Security Number:
Insured's Address, City, State and Zip Code:			
Telephone Number: Which phone number is your preferred method of contact: Home ☐ Work ☐ Cell ☐ Home: Work: Cell:			
Insured's Date of Birth / /	Age:	Sex:	Marital Status:
Name of Insurance:			
Tertiary Insurance Address for Medical Claims: (Street or Post Office Box, City, State and Zip Code)			
Policy No.:	Group No.:		
Is prior authorization needed for a visit to a specialist? Yes ☐ No ☐ If yes, Prior Authorization Reference/Tracking No.: _____			

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PREFERRED METHOD TO RECEIVE MESSAGES AND REMINDERS:

HOW WOULD YOU PREFER TO RECEIVE MESSAGES AND/OR BE REMINDED ABOUT APPOINTMENTS?

PLEASE CHECK ONE:

☐ **TEXT MESSAGE: CELL PHONE NUMBER** _____
(PATIENT RESPONSIBLE FOR ANY COSTS INCURRED BY CELL SERVICE FOR TEXT MESSAGING)

☐ **E-MAIL:** _____

☐ **PHONE CALL: PREFERRED NUMBER** _____

Do we have your permission to:

Leave a message regarding upcoming or missed appointments on your answering machine or voice mail? ❑ Yes ❑ No

Leave a message regarding biopsy or other test results on your answering machine or voice mail? ❑ Yes ❑ No

Discuss upcoming or missed appointments and/or biopsy or other test results with a member of your household? ❑ Yes ❑ No

If yes, whom: _____ Relationship to patient: _____

Discuss your financial information, insurances, payments, charges, adjustments with a member of your household? ❑ Yes ❑ No

If yes, whom: _____ Relationship to patient: _____

Patient or Responsible Party Signature: _____ Date: ___/___/___

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge I have received a copy Larry E. Urry, M.D., P.C.'s Privacy Policy

Patient or Responsible Party Signature:_____ Date: ___/___/___

MEDICAL CONSENT TO TREAT AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

I am voluntarily seeking medical care and hereby consent to medical treatment, procedures, laboratory tests, and other health care services provided or referred by Larry E, Urry, M.D., Allyx Bowthorpe, APRN, Tyler Newman, PA, or any other medically credentialed provider(s) under the direction of Larry E. Urry, M.D..This agreement of "Medical Consent to Treat and Authorization to Release Medical Records" may be revoked by me at any time by written notification and is valid until revoked.

I have the right to refuse specific treatment or procedures.

I have the right to discuss my diagnosis (if known), the nature and purpose or a proposed treatment or procedure, alternatives (regardless of their cost or the extent to which the treatment options are covered by medical insurance), the risks and benefits of the alternative treatment or procedure, and the risks and benefits of not receiving or undergoing a treatment or procedure.

I hereby authorize Larry E. Urry, M.D., Allyx Bowthorpe, APRN, Tyler Newman, PA or any other medically credentialed provider(s) under the direction of Larry E. Urry, M.D. to bill my insurance plan(s) as appropriate to process primary, secondary, and/or supplemental insurance claims, insurance applications, laboratory and/or pathology tests, and/or prescriptions.

I authorize the release of medical information to my primary care or referring physician, to consultants if requested. I understand that my medical record may contain reports, test results, and notes that only a physician may interpret. I understand that I should contact my physician regarding entries made in my medical record to prevent any misunderstanding of the information provided.

I understand that once my health information is released, Larry E. Urry, M.D. nor any other person employed by Larry E. Urry, M.D., dba DRUMD, may guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I am at least 18 years of age, an emancipated minor, or the parent/legal guardian of this patient under 18 years of age.

Patient or Responsible Party Signature:_____ Date: ___/___/___

AUTHORIZATION TO TREAT IN ABSENCE OF PARENT OR GUARDIAN

If my child(ren) is/are brought to the office by_____, I consent for my children to be treated and agree to be financially responsible for the cost of such care.

I UNDERSTAND THAT BY NOT SIGNING THIS SECTION MY CHILD(REN) MAY NOT BE SEEN BY ANY PROVIDER AT LARRY E. URRY, M.D., P.C. DBA DRUMD WITHOUT MYSELF OR ANOTHER LEGAL GUARDIAN PRESENT.

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____ Date: _____

FINANCIAL POLICY AND CANCELLATION NOTICE

THE PATIENT/RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL MEDICAL AND/OR AESTHETIC BILLS THAT RESULT FROM SERVICES RENDERED BY INDIVIDUALS EMPLOYED BY LARRY E. URRY, M.D., P.C..

- There is a **24 hours cancellation notice** required **for all appointments**. We reserve the right to charge **$50 for a missed office visit, $100 for a missed surgery appointment, and up to $150 for a missed hair removal, facial, FotoFacial©, peel, laser, or other medical or aesthetic appointment.**
- I hereby authorize payment of medical benefits to Larry E. Urry, M.D., P.C..
- **Co-payment is required before service is rendered.**
- **Patients without insurance and/or other cash-pay services are to be paid in full upon checkout on the day of service.**
- Payment is accepted in the form of cash, check or credit card (Visa, MasterCard, American Express, or Discover).
- **In the event of a returned check, your check is sent immediately to Express Recovery Services, Inc. wherein a minimum $25 return check fee will be assigned**. You agree to pay any additional charges assessed by Express Recovery Services, Inc.
- All delinquent accounts will be charged a 7% per annum (.058% per month) or a minimum of a 50 cent (.50) monthly finance charge whichever is greater.
- **In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed thirty-three percent (33%) of the unpaid balance.** In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees in addition to the collection fee. You authorize us to call you at any number you provide or at any number that we reasonably believe we may contact you (including calls to mobile, cellular, or similar devices) for any lawful purpose. You agree to pay any fee(s) or charge(s) that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. You will also be responsible for all additional costs, charges, and/or legal fees added by Express Recovery Services, Inc.
- You agree that a photocopy of this agreement is as valid as the original.

Patient or Responsible Party Signature: _____ Date: ___/___/__

Our paperwork is updated annually. Thank you for your cooperation in keeping your information current.

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Today's Date _____

Current Medications

	Reason for Use	Medication Name	Strength	How many times a day	When? AM/PM/With Meals/As Needed	Prescription Start Date	Prescription End Date
	Example: Acne	Solodyn	85mg	1	PM	9/1/16	9/30/16
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

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OFFICE USE ONLY:

Patient Name: _____

Patient Chart Number: _____

Patient ID: _____

Verify Type: ☐ **Driver's License** ☐ **Passport**

❑ **Other ID:** _____ **Type:** _____

ID Scanned into System ☐ **Yes** ☐ **No**

If no, reason: _____

Unaccompanied Minor:

Name of Individual who arrived with Patient: _____

Relationship of Individual to Patient: _____

Patient arrived without an accompanying adult ☐

Is there a Medical Power of Attorney in our records or Signed Consent to Treat? ☐ Yes ☐ No

If no, was parent notified by telephone ☐ Yes ☐ No

If yes, Telephone Number: _____

If no, date appointment is rescheduled: _____ or on Recall List: _____

Confirmed completion of Intake Documents ☐ Yes ☐ No

If no, reason: _____

Employee Name: _____

Employee Signature: _____ **Date:** _____