

DERMSPECIALISTS

PATIENT NAME _____ MARITAL STATUS _____ S M W D BIRTH DATE _____ AGE _____ SEX _____ M F

ADDRESS _____ CITY/STATE _____ ZIP _____

PHONE # _____ SOCIAL SECURITY # _____ PHARMACY _____

CELL # _____ EMPLOYER & PHONE # _____

EMERGENCY CONTACT & PHONE # _____

PRIMARY CARE PHYSICIAN _____ REFERRED BY _____

OTHER FAMILY MEMBERS TREATED HERE _____

NAME FAMILY OR FRIENDS TO WHOM WE MAY RELEASE YOUR MEDICAL INFORMATION _____

PRIMARY INSURANCE
SUBSCRIBER NAME _____ BIRTH DATE _____

SECONDARY INSURANCE
SUBSCRIBER NAME _____ BIRTH DATE _____

ID # _____

ID # _____

EMPLOYER _____

EMPLOYER _____

IF WE DO NOT RECEIVE PAYMENT FROM YOUR INSURANCE CARRIER WITHIN 30 DAYS, WE WILL ASK YOU TO CONTACT THEM TO GET YOUR BILL PAID.

ALL CHARGES WILL BECOME PATIENT'S FINANCIAL RESPONSIBILITY IF YOUR INSURANCE CARRIER HAS NOT PAID WITHIN 60 DAYS.

I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIAN.

PAYMENT IS DUE AT THE TIME OF SERVICE, AS ARE CO-PAYS AND DEDUCTIBLES, UNLESS PRIOR ARRANGEMENTS ARE MADE. HOW ARE YOU PAYING TODAY? CK _____ CASH _____ CC _____ THANK YOU.

I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) BY **DERMSPECIALISTS** TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO). FURTHER, **DERMSPECIALISTS** MAY CALL MY HOME OR OTHER DESIGNATED LOCATION AND LEAVE A MESSAGE ON A VOICE MAIL, ANSWERING MACHINE, OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALL PERTAINING TO MY CLINICAL CARE, INCLUDING LABORATORY RESULTS, AMONG OTHERS. **DERMSPECIALISTS** MAY MAIL TO MY HOME OR OTHER DESIGNATED LOCATION ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDER CARDS AND PATIENT STATEMENTS. I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. **DERMSPECIALISTS** RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED UPON WRITTEN REQUEST.

IF I DO NOT SIGN THIS CONSENT, **DERMSPECIALISTS** MAY DECLINE TO PROVIDE TREATMENT TO ME.

SIGNED _____ DATE _____

