HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

Your signature consents to use and disclosure of your protected health information for treatment, payment & health care operations. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Dermatology Clinic is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations;
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice;
- The Practice reserves the right to change the Notice of Privacy Policies;
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions;
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease;
- The Practice may condition treatment upon the execution of this Consent.

Would you like a copy of the HIPAA Notice of Privacy Form? ❒ Yes ❒ No

Do we have your permission to:

Leave a message on your cell phone answering machine? ❒ Yes ❒ No ❒ N/A
Leave a message at your place of employment? ❒ Yes ❒ No ❒ N/A
Discuss your medical condition with anyone other than yourself? ❒ Yes ❒ No ❒ N/A
If yes, with whom:

____________________________________ Relationship: __________________ Phone: _______________

____________________________________ Relationship: __________________ Phone: _______________

____________________________________ Relationship: __________________ Phone: _______________

____________________________________ Relationship: __________________ Phone: _______________

X____ ________________________________
Patient / Representative Signature Date

____ ________________________________
Representative Relationship to Patient Date

THE DERMATOLOGY CLINIC
OF ARKANSAS

501.623.6100 Ph#

866.511.3376 T.F.#
501.623.6187 Fax#

PATIENT REGISTRATION FORM

(Please present insurance/government issued photo ID card to receptionist)

Patient Name: ______________________ ______________ ______________________
First *Middle* *Last*

Address: ____

City: ____________________________ **State:** ________________ **Zip:** ______________

Home (   ) ____________ **Work (   )** _______________ **Cell (   )** _______________

Social Security Number: ______________________________ **D.O.B.** _____ / _____ / _____

Place of Birth (City & State) ____________________ **Email:** __________________________

Would You Like To Receive Text Message Reminders For Future Appointments? ☐ Yes ☐ No

SEX:	☐ Male ☐ Female
RACE:	☐ American Indian ☐ Asian ☐ Black/African American ☐ Other ☐ White ☐ Declined
ETHNICITY:	☐ Hispanic-Latino ☐ Not Hispanic-Latino ☐ Other ☐ Declined
MARITAL STATUS:	☐ Married ☐ Divorced ☐ Single ☐ Widowed

Language: ____

Primary Care Physician: ____________________ Referring Physician: ___________________

Pharmacy Name: _________________________ Phone or Zip Code: ____________________

RESPONSIBLE PARTY NAME AND ADDRESS (if other than the patient)

Name: _________________________________ Social Sec. #: ______________________
Address: _______________________________ City/State:_________________________
Employer: ______________________________ Work Phone: _______________________
D.O.B. _____ / _____ / _____

The following section applies if you are NOT the policy holder

Primary Insurance Name: ____
Policy Number: ____________________________ Group Number: ____________________
Policy Holder's Name: ____
Social Security #: _________________________________ D.O.B. _____ / _____ / _____

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. ***Please Check:*** ☐ Medicare ☐ Medicaid ☐ Private Insurance

X____ ______________________________
Patient/ Guardian Signature Date

N

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.

Payment is required in full for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payment and deductibles will be collected.

Any unpaid balance, after insurance payment, is due from the patient. Since our relationship is with the patient, the bill is the patient's responsibility. The patient will receive a monthly statement any time there is a balance on the patient's account that is considered patient responsibility. **If the entire balance cannot be paid in full, our business office can arrange a payment plan for the patient.**

Co-pays are due at the time of treatment. These amounts vary depending upon which managed health care plan the patient may have.

Payments Accepted: **Cash, Check, VISA, MasterCard, Discover, or American Express**

There is a $25.00 charge to the patient for returned checks due to insufficient funds or closed accounts.

We accept Medicare assignment and participate in a number of HMO's, PPO's and other managed care plans. We must have a copy of the patient's insurance card and all insured party information including date of birth and social security number to process the claim.

Financing options are available through

Please inquire at checkout.

MEDICAL RECORDS

Patient fee for copying of records is $.50 per page for the first 25 pages, and $.25 per page thereafter.
Please review your Explanation of Benefits from your insurance carrier.

If you have any questions or feel you are due a refund from The Dermatology Clinic, please contact our billing office at (501) 623-6100. We are always willing to be of assistance to you.

Your signature below signifies your understanding and willingness to comply with this policy.

X______________________________________ ______________________________
Patient Signature Date

THE DERMATOLOGY CLINIC
OF ARKANSAS

Patient Name: ____ DOB: ____________________

Please Circle One

Do you have pain related to the condition in which you're being seen for today?

YES **NO**

Do you smoke?

YES **NO**

How many days a **YEAR** do you drink 5 or more (men) or 4 or more (women) alcoholic drinks in a day?

0 **1** **2** **3** **4+**

If you are 6 months of age or older, have you received the flu vaccine?

YES **NO**

If you are 65 years of age or older, do you have an advanced care plan or surrogate decision maker?

YES **NO**

If yes, please provide their name and phone #: ____

Do you have a living will?

YES **NO**

Please check one:

- ☐ Full Code
- ☐ Do Not Resuscitate
- ☐ Do Not Intubate