

# HIPAA PATIENT CONSENT FORM

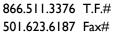
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice 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 No	□ Yes	□ No	
Do we have your permission to:			
Leave a message on your cell phone answering machine? Leave a message at your place of employment? Discuss your medical condition with anyone other than yourself? If yes, with whom:			☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A
	Relationship:		Phone:
X			
Patient / Representative Signature		Date	
Representative Relationship to Patient		Date	





## PATIENT REGISTRATION FORM

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

Patient Name:						
Address:		Middle	Last			
City:		State:	Zip:			
Home ( )	Work (	)	Cell ( ) _			
Social Security Numb	oer:		D.O.B	//		
Place of Birth (City &	State)	Email:				
Would You Like To F	Receive Text Messag	e Reminders For F	uture Appointments?	☐ Yes ☐ No		
SEX:	☐ Male ☐ Female					
RACE:	☐ American Indian	☐ Asian ☐ Black/A	frican American   Other	☐ White ☐ Declined		
ETHNICITY:	☐ Hispanic-Latino	☐ Not Hispanic-Lating	Other Declined			
MARITAL STATUS:		rced □ Single □ W				
Language:						
Primary Care Physician	n:	Refer	ring Physician:			
Pharmacy Name:		Phon	e or Zip Code:			
RESI	PONSIBLE PARTY	NAME AND ADDR	ESS (if other than the p	patient)		
Name:	Social Sec. #:					
Address:	City/State: Work Phone:					
Employer:		W	ork Phone:			
D.O.B/	/					
	The following section	on applies if you are	e <u>NOT</u> the policy holde	er		
Primary Insurance Nan	ne:					
Policy Number:		G	roup Number:			
Policy Holder's Name:			D.O.B	1 1		
Social Security #:			D.O.B	//		
f authorize the release medical benefits to the	of medical informati physician. Pleas	on necessary to procee Check:	cess this claim and also care ☐ Medicaid ☐	authorize payment of Private Insurance		
X						
<u>X</u> Patient/ Guardian Sign:	ature		Date			



## 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 **LareCredit** 



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



Patient Name:	DOB:					
Please Circle One						
Do you have pain rela	ted to the c	condition in whi	ch you're bei	ng seen for tod	ay?	
	YES	NO				
Do you smoke?						
	YES	NO				
How many days a YE	<b>AR</b> do you	ı drink 5 or mor	e (men) or 4	or more (wome	n) alcoholic drink	ks in a day?
	0	1	2	3	4+	
If you are 6 months of	age or old	er, have you red	ceived the flu	vaccine?		
	YES	NO				
If you are 65 years of	age or olde	er, do you have	an advanced	care plan or sur	rogate decision n	naker?
	YES	NO				
If yes, please pro	vide their	name and phone	e #:			
Do you have a living	will?					
	YES	NO				
Please check one:						
☐ Full Code ☐ Do Not Resuscitat ☐ Do Not Intubate	e					