PATIENT REGISTRATION / HIPAA AND OTHER CONSENTS

Patient Name: Last: _____ First: _____ MI: _____ Maiden: _____

Date of Birth: _____ Age: _____ Sex: Male/Female Social Security #: _____-____-_____ Marital Status: _____

Physical Address: _____ City/State/ZIP: _____

Mailing Address: _____ City/State/ZIP: _____

Phone: Primary: (____) _____-_____ Secondary: (____) _____-_____ Work: (____) _____-_____ Ext: _____

Email: _____ **Referring Dr/PCP**_____

Responsible Party Name: Last_____First_____

Address:_____

Home Phone:_____ Mobile Phone:_____

Emergency Contact Name: Name_____Phone_____

Relationship to patient:_____

HIPAA Consents: Please indicate a person(s) with whom we may discuss your health/account. If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. NOTE: If the patient is a minor, parent(s) must be listed.

- Name: _____ Relationship to Patient: _____ Phone: (_____) _____-_____
- Name: _____ Relationship to Patient: _____ Phone: (_____) _____-_____
- Name: _____ Relationship to Patient: _____ Phone: (_____) _____-_____

If you would like Dermatology Southwest to file with your Insurance these fields MUST be completed.

Primary: Insurance Company: _____ Policyholder: Last: _____ First: _____MI: ____

Policy ID #: _____ Group #: _____

(**Policyholder Info)**

Relationship to Patient: _____ Social Security #: _____-_____-_____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Phone: Primary: (____) _____-_____ Secondary: (____) _____-_____

Secondary: Insurance Company: _____ Policyholder: Last: _____ First: _____MI: ____

Policy ID #: _____ Group #: _____

(**Policyholder Info)**

Relationship to Patient: _____ Social Security #: _____-_____-_____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Phone: Primary: (____) _____-_____ Secondary: (____) _____-_____

Voicemail Consent: For your convenience, Dermatology Southwest will call to remind you about your upcoming appointments. Please check the following phone lines on which we may leave detailed information:

☐ Primary Voicemail ☐ Secondary Voicemail ☐ Work Voicemail ☐ I do not wish Dermatology Southwest to leave details on my voicemail.

By signing below I certify the above information to be true and correct.

Notice of Privacy Practice Acknowledgement: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have reviewed your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dermatology Southwest has the right to change its Notice of Policy Practices from time to time and that I may contact Dermatology Southwest at any time to obtain a current copy. I understand that I may request in writing that Dermatology Southwest restrict how my PHI is used or disclosed to carry out treatment, payment and healthcare operations.

- I am aware that for my safety and protection, video and audio surveillance may be used on Dermatology Southwest premises, in public areas only.

I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the physician on duty. I understand that no guarantee or assurance has been made as to the results, which may be obtained. I understand that I have the right to revoke this consent, in writing, except where Dermatology Southwest has already made disclosures in reliance on my prior consent. A photocopy of this signature is as valid as the original.

Patient or Parent/Guardian **Signature:** _____Date: _____

PRINT Patient or Parent/Guardian Name: _____ Parent/Guardian **Date of Birth:** _____