JAY S. ADAMS, M.D. • RUTH E. ADAMS, M.D. • ALAN TACK, M.D. • MAX GRATRIX, M.D.
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Medical Privacy Notice

HIPAA

Health Insurance Portability Accountability Act

In 1996, Congress passed a series of legislative acts designed to assure the security and confidentiality of medical records and information. This legislation is collectively known as HIPAA. All medical facilities and providers are required to comply with these requirements as of April 14, 2003.

Permitted uses and disclosures of your medical information:

1.) Treatment, Payment, and Healthcare Operations
2.) To communicate with your other physicians and healthcare providers
3.) To communicate with your insurance company for authorization and payment purposes
4.) Under rare circumstances, to comply with court orders, police, or national security directives
5.) To comply with public health directives laws and regulations

Other disclosures or uses of your personal health information, PHI, require your written permission.

You are entitled to:

1.) Inspect, copy, or amend your medical information
2.) Restrict the use of your medical information by informing us in writing
3.) File a written complaint with the office if you feel your medical privacy rights have been violated

We are additionally required to:

1.) Post a copy of our privacy policy in the waiting area
2.) Maintain a written privacy policy for the practice and provide you with a copy upon request
3.) Request that you read and sign a copy of this notice which will be placed in your chart
4.) Provide you with the information required to file a privacy complaint with our office or with the federal Office of Civil Rights, OCR, on request

I, ____ (**PRINT NAME**), acknowledge I have been given this form, offered a copy of the privacy policy, and had the opportunity to ask any questions.

PATIENT'S OR
LEGAL GUARDIAN'S SIGNATURE:________________________________ DATE SIGNED:__________________

FOR OFFICE STAFF ONLY:

The patient declined to sign and/or review or acknowledge this form.

SIGNATURE:________________________________ DATE SIGNED:______________________

1505 MEDICAL PARKWAY CARSON CITY, NEVADA 89703 TELEPHONE (775) 883-7811

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HIPAA DISCLOSURE AUTHORIZATION

PATIENT'S NAME:____ DATE OF BIRTH:___________________

PHONE #:_____________________________________

HIPAA regulations require we keep your health information confidential. You do have the right to grant access to this information to family, significant other, or any other person; please complete this authorization.

Please list those individuals to whom you authorize the release of your health information. (ie: medical condition, diagnosis, test results, appointments, and other pertinent health reports.)

NAME:_________________________________ PHONE #:________________________ RELATION:_______________________

NAME:_________________________________ PHONE #:________________________ RELATION:_______________________

NAME:_________________________________ PHONE #:________________________ RELATION:_______________________

NAME:_________________________________ PHONE #:________________________ RELATION:_______________________

<u>This authorization is valid for 3 years.</u>

PATIENT SIGNATURE:____ DATE SIGNED:___________________

CARSON DERMATOLOGY ASSOCIATES
Patient Registration Form

PATIENT INFORMATION:

NAME:____
LAST FIRST MIDDLE

MAILING ADDRESS:______________________________ ______________________ ____________
STREET #, NAME, AND APT/SUITE # CITY ZIP

SEX;______ MARITAL STATUS:________________ DATE OF BIRTH:__________________________

PRIMARY PHONE:______________________________SECONDARY PHONE:_____________________________ALTERNATE PHONE:__________________________

EMAIL:____ CAN WE TEXT YOU? Y / N IF SO, WHAT'S THAT NUMBER?_________________________

PATIENT'S EMPLOYER:____ EMPLOYMENT STATUS:_____________________________________

WHAT IS THE BEST WAY TO COMMUNICATE WITH YOU? (CIRCLE **ONE**) LETTER EMAIL PHONE

DO YOU LIKE TO GO BY ANY OTHER NAME THAN WHAT YOU HAVE GIVEN US? IF SO, WHAT NAME?:__________________________________

SMOKING HISTORY: NEVER CURRENT FORMER VACCINATIONS: (CURRENT YEAR) PNEUMONIA OVER AGE 65_____ FLU VACCINE_____

DO YOU HAVE A HISTORY OF SKIN CANCER?_______IF SO, WAS IT: BASAL CELL CARCINOMA SQUAMOUS CELL CARCINOMA MALIGNANT MELANOMA

DO YOU HAVE AN ADVANCE CARE PLAN?(CIRCLE ONE) YES NO

RESPONSIBLE/ INSURED PARTY INFORMATION:

RESPONSIBLE PARTY'S NAME:____ RELATION TO PATIENT:_______________________________
LAST FIRST

RESPONSIBLE PARTY'S MAILING ADDRESS:____ ________________________________ ___________
STREET #, NAME, AND APT/STE # CITY ZIP

SEX:______ DATE OF BIRTH:__________________ PRIMARY PHONE:_______________________ EMAIL:____

RESPONSIBLE PARTY'S EMPLOYER:____ EMPLOYMENT STATUS:_____________________________________

EMERGENCY CONTACT INFORMATION:

NAME:____ PHONE:___________________________________ RELATION TO PATIENT:__________________

REFERRED BY:____ PRIMARY CARE PHYSICIAN:____

Payment is required for all services at the time they are rendered. If your visit is provided under contracted insurance coverage, all co-payments, co-insurance, and deductibles are due at the time of service. Any account balances are delinquent after 30 days. Delinquent accounts will incur a monthly billing fee of $10 or 1.5%, whichever is greater. In addition to understanding the billing policy, I assign all insurance benefits and additional payer benefits to Carson Dermatology for services provided by them. I authorize release of medical information as necessary for insurance claims, applications, and prescriptions, and I authorize release to my primary care physician, referring physicians, as well as consultants, as needed.

____ ________________________________

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE **DATE**