CARSON DERMATOLOGY ASSOCIATES
Patient Registration Form

PATIENT INFORMATION:

NAME:_____
LAST FIRST MIDDLE

PATIENT'S ADDRESS:_____ _____ _____
STREET #, NAME, AND APT/SUITE # CITY ZIP

SEX;_____ TITLE (CIRCLE **ONE**): MR. MRS. MS. MISS SR. JR. II/III, ETC:_____

PRIMARY PHONE:_____ SECONDARY PHONE:_____ ALTERNATE PHONE:_____

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

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

IS THERE SOMEONE WHO HAS POWER OF ATTORNEY OVER YOU? Y / N IF SO, WHAT IS THEIR NAME?_____

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

MARITAL STATUS:_____ DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

PATIENT'S EMPLOYER:_____ EMPLOYMENT STATUS:_____

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:_____ TITLE (CIRCLE **ONE**): MR. MRS. MS. MISS SR. JR. II/III, ETC:_____

SOCIAL SECURITY #:_____ 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**

CARSON DERMATOLOGY

CHARLES E. CLEMMENSEN, M.D. * JAY S. ADAMS, M.D. * RUTH E. ADAMS, M.D. * ALAN TACK, M.D.*
LIESEL ERNST, PAC * MELANIE BUCKLEY, PAC * MELANIE ADAMS, PAC * MAX GRATRIX, M.D.

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/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:_____

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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 has no expiration date. It shall be termed when withdrawn in writing.</u>

PATIENT SIGNATURE:_____ DATE SIGNED:_____