Name:
Age: DOB:
DOS:
MRN: INS:
Doctor:

DERMATOLOGY SPECIALISTS

Patient Name: _____ **Birth Date**: _____ **Age**: _____
First M.I. Last

Responsible Party Name: _____ **Birth Date**: _____ **Relationship:** _____
(If patient is under 18) First Last

Address: _____
City State Zip

Gender : F or M Marital Status: ☐ Single ☐ Married ☐ Other

Preferred contact method (check mark one):

□ Home Phone: _____ □ Mobile Phone: _____ □ Work Phone: _____
(If patient is under 18, provide parent/guardian phone)

Email Address (recipient must be 18 or over): _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Pharmacy Name | Location | Phone: _____

Referring Physician | Clinic: _____

Primary Care Physician | Clinic: _____

This authorization allows Dermatology Specialists to discuss ALL ASPECTS of my protected health information and treatment (including but not limited to test results, biopsy results, billing information and prescription information) with the individual(s) listed below and release such information about me to such person(s):

Name: _____ Relationship: _____ Phone Number: _____
First Last

Authorization valid until revoked in writing by the patient (or patient representative).

- **ASSIGNMENT OF BENEFITS**: I hereby request that payment of Medicare or insurance benefits be made directly to Dermatology Specialists on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If for any reason my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.
- **CONSENT FOR TREATMENT**: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment and that I have the right to refuse the recommended treatment.
- **NOTICE OF PRIVACY PRACTICES**: I acknowledge I have been made aware of Dermatology Specialists privacy practices. I acknowledge receipt of Dermatology Specialists' Notice of Privacy Practices. I consent to be contacted by Dermatology Specialists, PA or their business associates at the physical addresses, email addresses or phone numbers provided.
- **RELEASE OF MEDICAL RECORDS**: I authorize the release of medical information to any physician/healthcare provider involved in my care including my primary care or referring physician, to consultants and also as necessary to process insurance claims and applications and to any person or entity outside of Dermatology Specialists for purposes of Dermatology Specialists health care operations. If I wish for anyone else to have access to my medical records I will ask for a Medical Record Release Form to name these people.
- **CONSENT TO TAKING PHOTOGRAPHS**: I consent that photographs may be taken of me or parts of my body only with the consent of the physician/provider and under such conditions approved by the physician/provider. The photographs shall be taken by my physician or by a photographer approved by my physician. The photographs shall be used for medical records. Should photographs and information relating to my case benefit medical books or professional journals, my permission will be asked and I will be provided a consent form for release of my information. Under no circumstances will I be identified by name.
- **CANCELLATION POLICY**: I acknowledge I have been made aware of Dermatology Specialists Missed Appointment & Cancellation Policy. I understand I may be charged a $50.00 fee or be dismissed from clinic if I miss a scheduled appointment, or fail to alert Dermatology Specialists 24 hours in advance of an appointment cancellation. If I would like a copy of the Missed Appointment & Cancellation Policy I will ask for one.
- **MEDICATION HISTORY CONSENT, ACCESS/QUERY OF RECORD LOCATOR SERVICE, PATIENT INFORMATION SERVICE, OR HEALTH INFORMATION EXCHANGE**: I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component of my care. I give my permission to allow Dermatology Specialists to obtain my medication history from my pharmacy, health plans, and other healthcare providers, and to access and/or query health information about me and the location of my health records through a record locator service, health information exchange or patient information service.

I have read and understand the above policies.

_____ _____
Patient or Legal Representative Signature Date

_____ _____
Patient or Legal Representative Printed Name Date