ALLIANCE DERMATOLOGY & MOHS CENTER

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PATIENT NAME: **DOB:**

ADDRESS:

CITY: **STATE:** **ZIP:**

WHEN ALLIANCE DERMATOLOGY HAS TO CALL AND LEAVE A MESSAGE

PLEASE NOTE: ALL NUMBERS LISTED BELOW ARE SUBJECT TO PHONE OR TEXT CONFIRMATION FOR UPCOMING APPOINTMENTS

WHAT NUMBER DO YOU WANT CALLED **1ST**:_____ HOME CELL WORK

WHAT NUMBER DO YOU WANT CALLED **2ND**:_____ HOME CELL WORK

PRIMARY CARE PHYSICIAN (PCP):

WHAT PHARMACY DO YOU PREFER: **LOCATION:**

WHAT EMAIL DO YOU WANT TO USE FOR YOUR ONLINE PORTAL:

EMERGENCY CONTACT

NAME + RELATIONSHIP:_____**PHONE**:_____

GUARANTOR/RESPONSIBLE PARTY

NAME + RELATIONSHIP:_____**DOB**:_____

MAY WE DISCUSS YOUR MEDICAL INFORMATION WITH ANYONE?

NAME:_____**RELATIONSHIP**_____**PHONE:**_____

NAME:_____**RELATIONSHIP**_____**PHONE:**_____

MEDICAL RECORDS RELEASE

_____INITIAL

I HEREBY GIVE CONSENT FOR ALLIANCE DERMATOLOGY TO DISCLOSE MY MEDICAL INFORMATION TO THE ABOVE LISTED PERSON(S). I AM AWARE THAT BY SIGNING THIS CONSENT, ANY AND ALL MEDICAL INFORMATION MAY BE DISCUSSED WITH THE PERSON(S) I DESIGNATE. THIS CONSENT WILL REMAIN IN EFFECT UNTIL OTHERWISE REQUESTED.

NOTICE OF PRIVACY PRACTICES ACKNOWLDEGEMENT

_____INITIAL

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996, HIPAA, IS A FEDERAL PROGRAM AS DETAILED AT LENGTH IN THE ATTACHED FORM. BY INITIALING, I ACKNOWLDEGE THAT I UNDERSTAND THE HIPAA POLICY AND MAY RECEIVE A DETAILED EXPLANATION AT ANY TIME UPON REQUEST TO KEEP FOR MY RECORD.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

_____INITIAL

I AUTHORIZE PAYMENTS OF MEDICAL BENEFITS TO THE PROVIDER FOR SERVICES RENDERED OR TO BE RENDERED IN THE FUTURE WITHOUT OBTAINING MY SIGNATURE ON EACH CLAIM SUBMITTED, AND THE SIGNATURE WILL BIND ME AS THOUGH I PERSONALLY SIGNED THE CLAIM. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR MY INSURANCE TO PAY THE CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED AND THAT IF THIS ACCOUNT SHOULD BE REFERRED TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ANY COLLECTION AND/OR LEGAL FEES. I HAVE READ AND UNDERSTAND THE OFFICE POLICY AND PROCEDURES. PLEASE BE ADVISED THAT IF A BIOPSY IS PERFORMED, THE SPECIMEN(S) WILL BE SENT TO AN OUTSIDE LABORATORY FOR EITHER SLIDE PREPARATION AND/OR PATHOLOGY READINGS. THIS LABORATORY HAS ITS OWN SET OF FEES AND YOU WILL RECEIVE A BILL FROM THEIR FACILITY. IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THIS BILL, PLEASE CONTACT THE LABORATORY DIRECTLY; THEIR PHONE NUMBER SHOULD BE PRINTED ON YOUR BILL.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE, AND HEREBY ATTEST THAT ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE:_____**DATE**:_____