

Personal Information (of Patient):

Last Name: _____ First Name: _____ Middle Initial: _____
Address _____ Date of Birth ____/____/____ SSN ____ - ____ - ____
City, State, ZIP: _____ Sex: Male Female
Home Phone ____ - ____ - ____ Cell Phone ____ - ____ - ____ Referred By _____
Employer _____ Work Phone ____ - ____ - ____ Ext _____
Married Single Widowed Divorced Separated 18 years old or younger Retired

Emergency Contact: _____
Last Name First Name
____ - ____ - ____ Ext _____
Home Phone Work/Cell Phone Relationship to patient

Insurances: (Please fill this out even if cards have already been provided)

Primary Insurance: _____		Secondary Insurance _____	
Ins. ID # _____	Group # _____	Ins. ID # _____	Group # _____
Subscriber Name	D.O.B	Rel. to patient	Subscriber Name
			D.O.B
			Rel. to patient

HIPAA Acknowledgement:

I, _____, have been presented with and read a Privacy Notice explaining my rights regarding my Individually Identifiable Health Information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other healthcare operations. Other uses of my IIHI will require an authorization from me for the specific intention of disclosure. If there are any parties that I wish to be privy of any or all of my IIHI including family members (eg. spouse, significant other, children, parents etc), I will indicate below.

Patient's signature Printed Name Date

You may discuss biopsy results with the following individual, _____, at all times, when I am unavailable or when there is an emergent/life-threatening circumstance.

Billing Authorization:

I, _____, hereby authorize AllPhases Dermatology, LLC, to apply for benefits on my behalf for covered services rendered by AllPhases Dermatology and request that the payments from Medicare and/or _____ be made directly to AllPhases Dermatology, LLC (or, in the case of Medicare Part B, to myself or to the party who accepts assignment).

I certify to the information I have reported with regard to my insurance coverage and further authorize the release if any necessary information, including medical information for this or any related claim, to the billing agent, (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration)/Medicare and/or _____. I also agree to pay any and all collection and attorney fees in the event of non-payment. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me, or the above named carrier, in writing at any time.

Insured's signature Printed Name Date

AllPhases Dermatology Policies Acknowledgement

I acknowledge that I have been presented with and read the policies governing the practice of AllPhases Dermatology, LLC and will adhere to them. If there are any circumstances that will prevent me from abiding by these rules, I will discuss and receive a waiver at the sole discretion of the Office Administrator of AllPhases Dermatology, LLC. I hereby agree to be responsible for any violation of any of these policies monetarily or otherwise.

Insured's signature Printed Name

