CARROLLTON DERMATOLOGY – SPRING BROOK DERMATOLOGY

Patient Information

Full Name: _____

Date of Birth: _____ Marital status: _____Occupation _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone ( ) _____

Mobile Phone ( ) _____

Work Phone ( ) _____

Email address: _____

Name of Emergency Contact Person: _____

Emergency Contact Phone: ( ) _____ Relationship to Patient: _____

Referring Physician, if any: _____

Individuals with whom the practice may share my protected medical information and account information:

_____

_____

Please provide a copy of the patient's/guarantor's current insurance card and driver's license.

If the patient is a minor, we require consent for treatment from a parent or legal guardian.

Please provide a list of all current medications and allergies. If you did not bring a list, please write your current medications on the back of this sheet.

By my signature, I represent that: the provided information is correct to the best of my knowledge; I have had the opportunity to review the privacy and financial policies of the practice; and I consent to treatment by the physicians and/or staff members of Carrollton Dermatology – Spring Brook Dermatology.

_____ _____

Patient or Legal Guardian – Signature Date

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice. We will not use or share your information other than as described here unless you tell us we can in writing. Let us know in writing if you change your mind.

When it comes to your health information, you have the following rights:

- To get an electronic or paper copy of your medical record. We may charge a reasonable, cost based fee.
- To ask us to correct your medical record if you believe it is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request confidential communications. You can ask us to contact you in a specific way (e.g. home or office phone) or to send mail to a different address.
- To ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your insurer. We will agree to your request unless we are required by law to share that information.
- To get a list of those with whom we've shared your information for six years prior to the date of your request. We will include all disclosures except those about treatment, payment and health care operations. We may charge a reasonable, cost based fee.
- To ask for a paper copy of this notice at any time, which we will provide promptly.
- To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- To file a complaint if you feel your rights are violated. You can contact us directly at 404-843-2114, or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
- To choose how and what we share with family, close friends or others involved in your care. If you are not able to tell us your preference (e.g. if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety. We will not sell your information. We may contact you for marketing or fundraising efforts, but you can tell us not to contact you again.

We are allowed or required to use/share your information in order to: help with public health and safety issues; do research; comply with the law; respond to organ and tissue donation requests; work with a medical examiner or funeral director; address workers' compensation, law enforcement and other government requests; respond to lawsuits and legal actions.

I give permission to contact me via telephone, text message or email at the numbers/addresses provided by me under contact information, unless specifically stated otherwise. I understand that photographs of me/my condition may be taken for documentation purposes. I give permission for use of these photographs for educational or scholarly publication purposes, after all personal identifying features have been removed.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

_____ _____

Patient or Legal Guardian – Signature Date

CARROLLTON DERMATOLOGY – SPRING BROOK DERMATOLOGY

Patient Acknowledgement Regarding Financial Responsibility

In order for us to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the patient's obligations and how to meet them. In exchange for services rendered, each patient or patient's guarantor agrees:

- To authorize payment of medical and surgical benefits to us, which would otherwise be payable to you.
- To pay for all non-covered charges, co-pays, co-insurance, deductible and out-of-network charges at the time of service or when otherwise advised. If this is not possible, you agree to contact our office BEFORE services are rendered. If we have to send you a statement for your copay or you fail to notify us of an appointment cancellation at least 24 hours in advance, you will incur a $35 processing fee per occurrence.
- To provide us with a copy of your most recent insurance card or other proof of insurance and/or register with the receptionist at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit, and your insurance company subsequently denies our claim, you are personally responsible for any and all charges. Additionally, we may need to reschedule your visit if you do not have your authorization or referral.
- To monitor your insurance company's payment of your account and if unpaid 30 days after the date of service, to contact them regarding their non-payment. You also agree to cooperate with us in resolving the unpaid status of your account.

As a courtesy to our self-pay patients seeking routine dermatological care, we will provide a reduced charge for payment made at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, we will not be responsible for filing claims to any insurance company nor will we accept payment on a discounted rate from the insurance company. In the event we receive a payment from an insurance company under this circumstance, we will refund the money to the insurance company.

I understand that any specimens collected for culture, biopsy or other testing will be sent to an outside laboratory. Charges for such testing will be billed directly from the outside facility and are separate from the office charges billed by Carrollton/Spring Brook Dermatology.

As a patient or guarantor of a patient, I agree that in consideration of the services rendered by the practice, that I am individually obligated to pay for all services in accordance with the regular rates, terms and conditions of Carrollton/Spring Brook Dermatology. In the event an account is sent to a collection agency or attorney for collection of an amount 90 days or older, the patient and/or guarantor agrees to pay the collection fee, including any accrued interest and all applicable bank fees incurred for a returned check.

I voluntarily consent to healthcare treatment from the physicians and staff at Carrollton/Spring Brook Dermatology. I am aware that the practice of medicine is not an exact science and no guarantees have been made to me regarding the results of treatment or examinations by my provider. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

_____ _____

Patient or Guarantor – Signature Date