UPTOWN DERMATOLOGY, P.A.

PATIENT REGISTRATION AND CONSENT FORM

PATIENT INFORMATION (please print clearly with full detail)

Patient's Last Name: _____ Patient's First Name: _____ Middle Initial: ____

Date of Birth: _____ Sex: ☐ Male ☐ Female How would you like to be addressed? _____

Street Address/Apt #: _____ City & State: _____ Zip Code: _____

E-mail: _____ ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone: (____) _____ Patient's Employer: _____

Business Phone: (____) _____ Referring Physician and Location: _____

Cell Phone: (____) _____ Emergency Contact (Name & Phone): _____

Pharmacy Name: _____ Address: _____

RESPONSIBLE PARTY INFORMATION (if different from Patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Relationship to Patient: _____

Street Address/Apt #: _____ City & State: _____ Zip Code: _____

Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____

PRIVACY INFORMATION

Employees of this office must have your permission to relay your medical information on the phone. Please let us know how you would like to be contacted. If you do not give us specific permission to speak to your family members we will assume that you do not want any information relayed to anyone in your household.

Please ***check*** ways we may communicate with you.

☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** ☐ **E-mail**

Please specify the name(s) of people who you authorize this office to discuss your medical care and test results with:

_____

May we leave benign pathology reports or normal laboratory results on your home answering machine? Yes ☐ or No ☐

May we leave benign pathology reports or normal laboratory results on your cell phone voice mail? Yes ☐ or No ☐

_____ Patient/Guarantor's initials to acknowledge

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and

The patient/guarantor understands:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

_____ Patient/Guarantor's initials to acknowledge

ASSIGNMENT AND RELEASE

Your initials and signature acknowledges your understanding of the Privacy and Patient Consent sections on this form. Your signature also authorizes Uptown Dermatology, P.A. to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when an assigned claim is filed. "I authorize that any benefits due be paid directly to my physician. I also understand payment is expected at the time of service (all co-pays, co-insurance, deductible and balances due must be paid when the service is given)."

_____ _____ _____

Patient Signature Parent Signature (if patient is a minor) Date