Today's date: _____/_____/2016 **Patient Registration**

Last Name _____ First Name _____ M.I._____

Your Social Security # _____ Male / Female Your Date of Birth _____/_____/_____

Mailing Address _____ City, State _____ Zip _____

Home Phone _____ May we leave messages? ☐ ☐ Cell phone_____

Work Phone_____ May we call you at work? ☐ ☐ Employer Name_____

Marital Status M S D W Spouse's Name (*if applicable*) _____Spouse's Employer_____

Emergency Contact (outside of household): Name_____ Relationship_____

Contact's Phone: ( )_____

Please list family members who are patients here _____

Primary Care Physician's Name _____ Phone _____

*****List e-mail address for appointment reminders & online bill pay:*** _____

***FOR MINOR-AGE PATIENTS*** (*Complete if patient is under 18 years old*)

Mother's Name _____Work Phone _____

Father's Name _____ Work Phone _____ Patient lives with _____

Name of person bringing in patient _____ Relationship _____

Address _____ City, State _____ Zip _____

Social Security # _____Home Phone _____ Work Phone _____

Date of Birth _____ Employer _____

**FINANCIAL RESPONSIBILITY STATEMENT , CONSENT TO TREATMENT, HIPAA CONSENT, RELEASE OF INFORMATION AUTHORIZATION AND CANCELLATION POLICY**

I consent to the treatment necessary for the care of the above-named patient.
The "Spencer Dermatology's Notice of Privacy Practices" has been made available to me.
I authorize the release of my medical records to the referring and family physicians.
I authorize the release to my insurance companies those records necessary to determine payable benefits.
I authorize fax transmittal of my medical records to authorized parties.
I authorize and request that insurance payments be made directly to Spencer Dermatology Assoc., LLC.
I acknowledge full financial responsibility for services rendered, including deductibles and co-insurance.
I agree to pay fees for checks returned by the bank.
In the event that my account is referred to a collection agency, I agree to pay all collection costs including $50 office collection fee, 35% collection agency fee for total account balance and reasonable attorney's fees.
I understand that if I am unable to keep my appointment, I must cancel at least **24 hours in advance**.
I acknowledge full financial responsibility for the **$50 administrative fee** charged due to my failure to keep or cancel an appointment, and understand that these fees cannot be billed to my insurance company.

_____ Date_____/_____/2016 2017_____
Patient Signature

_____ Date_____/_____/2016 2018_____
***Parent or Guardian Signature* (*if patient is a minor*)**

2019_____

**PLEASE COMPLETE OTHER SIDE**

Spencer Dermatology Associates, LLC

**PATIENT CONSENT FORM FOR PURPOSES OF TREATMENT, PAYMENT, AND OTHER ASPECTS OF MY MEDICAL CARE IN THIS OFFICE**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. 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.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

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 Accountability Act of 1996 (HIPAA).

## The patient understands that:

- 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 Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may require full payment at the time of service if your insurance cannot be filed because a signed Consent is not on file.

*****PATIENT: PLEASE COMPLETE BELOW !*****

***BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE BEEN OFFERED THE 09/23/13 VERSION OF OUR HIPAA PRIVACY NOTICE.***

***Please check below: My protected health information, including diagnosis, appointments and billing:***

____ ***MAY NOT*** ***be disclosed***

_____ ***MAY*** *be disclosed to the following individual(s):*

_____

_____

**This Consent was signed by:** _____

Printed Name – Pt or Representative (if POA for pt or a minor pt)

_____ ___/___/2016

Signature

Relationship to patient (if other than patient):_____

*****Note that this authorization will remain in effect unless revoked by you in writing*****

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***Practice Representative Witness:*** _____ ___/___/2016

Signature