PATIENT INFORMATION

ATOMIC DERMATOLOGY
Vicki Haines DCNP

ARE YOU A PREVIOUS PATIENT OF VICKI HAINES? YES NO

NAME:_____
LAST FIRST MIDDLE

MAILING ADDRESS: _____
CITY STATE ZIP

***DATE OF BIRTH** _____/_____/_____ ***GENDER:** ___ MALE ___FEMALE ***LAST 4 SSN**_____

CONTACT INFORMATION (PLEASE CHECK PREFERRED CONTACT METHOD)

- ☐ HOME (_____) _____ OK TO LEAVE MESSAGE? Y N
- ☐ CELL (_____) _____ OK TO SEND TEXT MESSAGE Y N
- ☐ WORK (_____) _____
- ☐ EMAIL _____

MARITAL STATUS: M S D W **PREFERRED LANGUAGE:** _____

ETHNICITY: _____HISPANIC/LATINO _____NOT HISPANIC/LATINO RACE_____
(WHITE, ASIAN, AFRICAN AMERICAN, ETC)

HOW DID YOU HEAR ABOUT US?_____

NAME OF REFERRING MEDICAL PROVIDER (IF APPLICABLE)_____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)
NAME:_____
LAST FIRST MIDDLE

*DATE OF BIRTH _____/_____/_____ *GENDER: ___ MALE ___FEMALE *LAST 4 SSN_____

MAILING ADDRESS: _____
CITY STATE ZIP

RELATIONSHIP TO PATIENT _____

INSURANCE: A COPY OF YOUR INSURANCE CARD(S) WILL BE TAKEN AT CHECK IN.
*****INSURANCE CARD MUST BE BROUGHT TO THE APPOINTMENT ALONG WITH A LIST OF YOUR MEDICATIONS AND ANY ALLERGIES TO MEDICATIONS.*****

EMERGENCY CONTACT INFORMATION:

NAME:_____

PHONE:_____ RELATIONSHIP:_____

PATIENT INFORMATION CONTINUED

PREFERRED PHARMACY:_____

NAME LOCATION

RELEASE OF INFORMATION:

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION INCLUDING APPOINTMENTS, TEST RESULTS, ACCOUNT INFORMATION WITH ANYONE OTHER THAN YOURSELF?

_____ YES _____ NO IF YES, PLEASE PROVIDE THEIR NAME AND PHONE NUMBER BELOW

NAME:_____

RELATIONSHIP: _____ PHONE: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

MY SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED AND/OR REVIEWED A COPY OF THE THIS CLINIC'S NOTICE OF USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION (NOTICE OF PRIVACY PRACTICES)

PATIENT OR RESPONSIBLE PARTY_____ DATE_____

POLICIES

MY SIGNATURE BELOW ACKNOWLEDGES MY UNDERSTANDING THAT ALL SERVICES AND PROCEDURES PERFORMED MAY BE SUBJECT TO DEDUCTIBLE, COPAY OR COINSURANCE BY MY INSURANCE CARRIER. I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR ALL UNPAID BALANCES FOLLOWING PAYMENT/PROCESSING BY MY INSURANCE CARRIER(S). I UNDERSTAND THAT PATHOLOGY, EXCISIONS, BIOPSIES, DESTRUCTION OF LESIONS AND OTHER PROCEDURES PERFORMED DURING THE COURSE OF A NORMAL OFFICE VISIT ARE OFTEN APPLIED TO THE DEDUCTIBLE.

BY SUPPLYING MY HOME PHONE NUMBER, MOBILE PHONE NUMBER, EMAIL ADDRESS, AND ANY OTHER PERSONAL CONTACT INFORMATION, I AUTHORIZE MY HEALTHCARE PROVIDER TO EMPLOY A THIRD PARTY OUTREACH AND MESSAGING SYSTEM TO USE MY PERSONAL INFORMATION, THE NAME OF MY CARE PROVIDER, THE TIME AND PLACE OF MY SCHEDULED APPOINTMENT, OVERDUE WELLNESS EXAM, BALANCES DUE, LAB RESULTS, OR ANY OTHER HEALTHCARE RELATED FUNTION. I ALSO AUTHORIZE MY HEALTHCARE PROVIDER TO DISCLOSE TO THIRD PARTIES, WHO MAY INTERCEPT THESE MESSAGES, LIMITED PROTECTED HEALTH INFORMATION (phi) REGARDING MY HEALTHCARE EVENTS. I CONSENT TO THE RECEIVING MULTIPLE MESSAGES PER DAY FROM MY HEALTHCARE PROVIDER, WHEN NECESSARY. I CONSENT TO ALLOWING DETAILED MESSAGES BEING LEFT ON MY VOICEMAIL, ANSWERING SYSTEM, OR WITH ANOTHER INDIVIDUAL, IF I AM UNAVAILABLE AT THE NUMBER PROVIDED BY ME.

LATE CANCELLATIONS AND MISSED/NO SHOW APPOINTMENTS MAY BE SUBJECT TO A $50.00 FEE PAYABLE BEFORE ANOTHER APPOINTMENT CAN BE SCHEDULED. WE UNDERSTAND THAT LIFE HAPPENS AND CIRUMSTANCES, AT TIMES, CAN BE BEYOND OUR CONTROL. PLEASE GIVE AS MUCH NOTICE AS POSSIBLE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT AS WE HAVE PATIENTS WAITING TO BE SEEN AND MAY BE ABLE TO FILL YOUR APPOINTMENT TIME.

COPAYS ARE DUE AT THE TIME OF SERVICE. ANY BALANCE UNPAID BY YOUR INSURANCE CARRIER WILL BE BILLED TO YOU ON A MONTHLY STATEMENT.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER FOR SERVICES RENDERED TO ME IN ORDER TO PROCESS CLAIMS ON MY BEHALF. I REQUEST THAT PAYMENTS OF AUTHORIZED MEDICAL BENEFITS BE MADE TO THE PROVIDER. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

SIGNATURE:_____**DATE:**_____