Patient Profile Form Please print information clearly
Please present insurance cards and photo ID to the receptionist. Thank You.

Name: _____ Date of Birth: _____

Address: _____ Apt #_____ City: _____ Zip: _____

SSN: _____/_____/_____ Age: _____ Gender: _____ Cell # _____ Home # _____

Email : _____ May we leave a detailed message at: Home#: **Yes** **No** Cell#: **Yes** **No**

Preferred method of contact for follow up reminders: ☐ **Phone** ☐ **Mail** ☐ **Email** Marital Status _____

Race: _____ Ethnicity_____ Preferred Language_____
RACE, ETHNICITY AND LANGUAGE OPTIONS LISTED ON CLIPBOARD

Employed by: _____ May we call you at work? If so, Work Phone: _____

Emergency Contact Person: _____ Relationship _____ Phone # _____

Insurance Information: This office will file insurance claims to the plans our providers are contracted with for all medically necessary services. Please remember that the patient or responsible party is responsible for all deductibles, copays, co-insurance and non-covered services. See our complete financial policy for details.

Primary Insurance: _______ Policy # _____ Group # _____
(If card not provided to staff)

Claims Mailing Address: _____

Name of Insured: _____ DOB:_____ Relationship: _____

Secondary Insurance: _____ Policy # _____ Group # _____
(If card not provided to staff)

Claims Mailing Address: _____

Name of Insured: _____ DOB:_____ Relationship: _____

Preferred Pharmacy Name: _____ Location: _____Phone: _____

- **Release of Information:** It is the policy of this office not to release your medical information to anyone without your written authorization. If you would like our office to discuss your confidential medical information (regarding test results, appointments, billing, or insurance) with someone other than yourself or your primary physician, please list the person(s) and their relationship below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Do you have a Medical Power of Attorney? **Yes** **No**

If yes, Name: _____ Phone: _____
Our office will require a copy of the court document for power of attorney in order to release information properly

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Name of Primary Care Physician: _____ Phone: _____

How did you hear of Medical Dermatology Specialists? Please specify. Thank You!

_____

PATIENT ACKNOWLEDGMENT OF RESPONSIBILITY

I, _____, hereby acknowledge that I have provided Medical Dermatology Specialists, PC, the most accurate and current information regarding my demographic and insurance related information. I understand that it is my responsibility to notify Medical Dermatology Specialists, PC of any changes in the above information as soon as possible. I have received, read and accept the financial policies of Medical Dermatology Specialists, PC.

Signature: _____

Relationship to Patient (if applicable): _____ Date: _____/_____/_____

RELEASE OF INFORMATION FOR CLAIMS PAYMENT

I authorize the release of any medical information necessary to process my claim and I further authorize payment of medical and/or surgical benefits to Medical Dermatology Specialists, PC.

Signature: _____ Date: _____/_____/_____

RECEIPT FOR NOTICE OF PRIVACY PRACTICE (8/23/2013)

I am a patient of Medical Dermatology Specialists and I hereby acknowledge receipt of their Notice of Privacy Practices, version 8/23/2013.

Name [please print]: _____ DOB:_____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

Patient's Date of Birth: _____

I hereby acknowledge receipt of Medical Dermatology Specialists' Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

PATIENT CONTRACT

By signing below, I understand that it is my responsibility as the patient or responsible party to obtain the necessary services (radiologic procedures, laboratory studies, consultations, follow up visits, etc) that have been ordered by Medical Dermatology Specialists. In the event the services are not obtained, the patient/responsible party agrees that neither the physician nor the practice is liable for complications arising from delay in diagnosis or delayed implementation of appropriate management.

Signature: _____ Date: _____/_____/_____

PERMISSION TO OBTAIN MEDICATION HISTORY

By signing below, I (as the patient or legal guardian of the patient) will allow Medical Dermatology Specialists to obtain my medication history from pharmacy clearinghouse. Patient's electronic medication history may come from two sources: pharmacies that report dispensed medication to pharmacy clearinghouse and from insurance payers who report medication claims to pharmacy clearinghouse.

Signature: _____ Date: _____/_____/_____

Medical Dermatology Specialists

MDS

FINANCIAL POLICY

To Our Patients:

Charges are determined by services rendered to each patient. Additional fees are charged for in-office procedures and laboratory/pathology services, in addition to an office visit fee. Payment in full is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Obtaining referral forms or pre-authorization is the responsibility of the patient. In the absence of appropriate referrals or pre-authorizations, the patient is responsible for payment in full for services rendered.

The office accepts payment in the form of cash, check, or credit cards (visa, mastercard or discover). In the event of a surgical procedure, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay for any unmet deductible, non-covered services, co-insurance and copayments. In the event that your account must be turned over to a collection agency, you will be held responsible for a collection fee not to exceed twenty five percent.

Please consider that your appointment time is reserved especially for you. We ask that you provide a least 24 hours notice if an occasion arises and you need to cancel your appointment. **We reserve the right to charge a fee for non-cancelled appointments, in the amount of $50.00-$100.00.**

For Patients with Insurance: We bill insurance carriers that our providers are contracted with. **Copayments, co-insurance and deductibles are due at the time of service.** Since your agreement with your insurance carrier is a private one, if the insurance carrier has not paid within sixty days of billing, professional fees are due and payable in full from the patient or responsible party.

AHCCCS Patients: All AHCCCS patients must provide valid AHCCCS card and eligibility along with necessary prior authorizations numbers and/or referrals for services. Copays are collected at check-in.

Surgery Fees: All copays, deductible and co-insurance for covered surgical procedures are due prior to surgery. Prior Authorization may be required by your carrier.

Non Covered Services: Any care not covered for by your existing insurance coverage will require payment in full at the time service is rendered.

Personal Injury Cases: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

Yearly Skin Screenings: Periodic preventive skin screenings may or may not be covered under your health insurance policy; however, they may be required by your physician.

Delinquent Accounts: Accounts past due are subject to collection. All fees, including (but not limited to) balance due, collection agency fees, attorney fees and court fees will be the responsibility of the patient or legal guardian. Unpaid accounts will be turned over to a collection agency for further action and the patient will be unable to receive further services from the office.

Thank you for choosing Medical Dermatology Specialists, PC.
If you have any questions about our financial policy, please call us at 602.354.5770.

1331 N. Seventh Street, Suite 250 • Phoenix, AZ 85006 • T: 602.354.5770 • F: 602.354.5607
www.medicaldermatologyspecialists.com

Medical Dermatology Specialists

NOTICE OF PRIVACY PRACTICES (updated 8/23/2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIONPLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a dermatologist sending records to the primary care physician.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- We may disclose PHI of minor children to their parents or guardians unless disclosure is otherwise prohibited by law.

- We may disclose PHI about you if required by international, federal, state or local law.

- We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing services and this business associate is obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

- We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration (“FDA”) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone (including leaving a message) or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to a summary or explanation of your PHI, rather than the entire record
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to an electronic copy of your medical records
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

Medical Dermatology Specialists

This notice if effective as of August 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy on our website at www.medicaldermatologyspecialists.com and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. Feel free to contact the Practice Compliance Officer at Medical Dermatology Specialists (602) 354-5770 for more information, in person or in writing. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.