

PATIENT INFORMATION

PATIENT DEMOGRAPHICS

First Name:	Middle:	Last Name:
Date of Birth:	Sex:	Nickname:
Marital: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Last 4 Digits of Social Security Number : XXX-XX-_____	
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email:	Preferred Language:	
Preferred Phone Communication: <input type="checkbox"/> Leave a Message with Detailed Information <input type="checkbox"/> Leave a Message with a Call-Back Number Only		
How did you hear about our office?		

GUARANTOR INFORMATION

First Name:	Last Name:	
Date of Birth:	Relationship to Patient:	
Phone:	Driver's License#:	State:
Address:		
City:	State:	Zip Code:

PATIENT INSURANCE | POLICY HOLDER INFORMATION

First Name:	Last Name:
Date of Birth:	Relationship to Patient:

Please bring the patient's current insurance card and a valid ID, to the front desk when checking in for the appointment. The patient's insurance and ID will be scanned into the system at that time.

NOTICE OF PRIVACY PRACTICES

I have been given a copy and have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of **U.S. Dermatology Partners**. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

CANCELLATION POLICY FOR APPOINTMENTS

It is my responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. **U.S. Dermatology Partners** reserves the right to charge a fee if the appointment is not cancelled at least 24 hours in advance. Additionally, the office reserves the right to reschedule appointments for which I am late. Special types of appointments require a deposit to reserve the appointment date. **U.S. Dermatology Partners** reserves the right to charge a fee or retain the deposit if the appointment is not cancelled at least 72 hours in advance.

COSMETIC SERVICES AND RETAIL SALES

Payment for cosmetic services is required in full prior to the provision of the service. Due to the nature of cosmetic products, exchanges/refunds may not be allowed.

FINANCIAL POLICIES

- I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependent, regardless if they are covered by my insurance company, Medicare and/or supplemental policy.
- Payment is required at the time services are rendered. **U.S. Dermatology Partners** is allowed by contract with your insurance company to collect the copayment and/or co-insurance and any unmet deductible at the time of service. The amount collected is estimated based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.
- Insurance coverage is not a guarantee of payment. I understand I am responsible for any remaining balance not covered by my insurance company, Medicare and/or supplemental policy. It is my responsibility to contact them if I have questions regarding my benefits and coverage.
- I understand that if I have a surgical procedure or biopsy performed that requires further examination by a Pathologist, there are three separate charges that will occur, as required by my health insurance plan: (1) a charge by my treating provider for collecting the specimen; (2) a charge by the Pathologist, a medical doctor, to examine the specimen; and (3) a charge by the laboratory preparing the specimen for the pathologist. I understand that I will be billed separately by my treating provider, the pathologist, and the laboratory.
- I understand that my insurance company, Medicare and/or supplemental policy may have a preferred lab for blood work. It is my responsibility to know which preferred lab I can use, and to inform my provider at the time of service.
- I understand that a fee may be assessed for returned checks.
- I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information.

The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:	Patient Date of Birth:
Parent / Legal Guardian Printed Name:	Relationship:
Signature:	Date:

PATIENT CONSENTS

CONSENT FOR TREATMENT

I authorize **U.S. Dermatology Partners**, its employees, and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

CONSENT FOR PHOTOS

I understand that during the course of treatment, photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

CONSENT FOR FILING INSURANCE CLAIMS

I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, **U.S. Dermatology Partners** is required to keep my signature on file. I hereby authorize **U.S. Dermatology Partners** to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I also authorize **U.S. Dermatology Partners** to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to **U.S. Dermatology Partners**. I further understand that should my account become delinquent, I shall pay the reasonable collection and attorney's fees of **U.S. Dermatology Partners**, if any.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY

I understand that to offer the best patient care, **U.S. Dermatology Partners** will retrieve my prescription history that has been ordered and filled through an EHR system. I authorize **U.S. Dermatology Partners** to import the prescription history obtained through an EHR system into my electronic chart.

CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS

I authorize U.S. Dermatology Partners to send me automated SMS text messages, phone calls, or emails to provide appointment and refill reminders, information regarding my treatment, and additional information regarding its dermatology-related products or services, educational information regarding my health, case management or care coordination messages, to direct or recommend alternative treatments, therapies, health care providers, or settings of care that may benefit me, and to provide quality of care surveys provided by U.S. Dermatology Partners. I understand that message/data rates may apply to messages sent by U.S. Dermatology Partners under my cell phone plan. I authorize U.S. Dermatology Partners and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring-less calls, and emails to provide me with my bill and to remind me to pay for services provided by U.S. Dermatology Partners, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive any and all communications.

PHI COMMUNICATION PREFERENCES

I authorize **U.S. Dermatology Partners** to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals, as indicated below. This authorization is voluntary, and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my **protected health information (PHI)** may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

☐ I elect **not to authorize disclosure** to any individuals at this time

☐ I elect **to authorize disclosure** to the below list of individuals:

First & Last Name:	Relationship:	Phone:	Medical	Billing
		()	<input type="checkbox"/>	<input type="checkbox"/>
		()	<input type="checkbox"/>	<input type="checkbox"/>
		()	<input type="checkbox"/>	<input type="checkbox"/>

Communication for benign (non-cancerous) test results	Phone
I hereby allow all benign (non-cancerous) test results to be put in a voice message on the phone number indicated in the box.	()

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:	Patient Date of Birth:
Parent / Legal Guardian Printed Name:	Relationship:
Signature:	Date:

**As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI) and to notify affected individuals following a breach of unsecured PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your PHI to treat you (e.g., a doctor treating you for a condition asks another doctor about your overall health condition).
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us (e.g., giving information about you to your health insurance plan so it will pay for your services).
3. **Health Care Operations.** Our practice, and its affiliated entities and management company, may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment utilizing an automated phone system, a personal call, text or by mail. This notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
7. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
8. **Release of Information to Family/Friends.** Our practice will routinely disclose to your responsible party(ies) the PHI directly relevant to his/her involvement with your health care, PHI related to payment of your health care, and PHI used for notification purposes. Our practice may release your PHI to another responsible party(ies) you identify, that is involved in your care.
9. **Marketing.** We will not use or disclose your medical information for marketing purposes without your prior written authorization.
10. **Sale of PHI.** We will not sell your PHI without your prior written authorization. **Please note that our practice does not provide mental health services and therefore does not maintain psychotherapy notes.**

C. USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI:

1. **Public Health Risk Reporting.** Our practice may disclose your PHI to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.
2. **Law Enforcement.** Your PHI may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

3. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.
4. **Disclosures Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
5. **Responding to Lawsuits.** We can share PHI about you in response to a court or administrative order, or in response to a subpoena.

D. YOUR RIGHTS REGARDING YOUR PHI

You have the certain rights regarding the PHI that we maintain about you, and you may ask us how to exercise any such rights. These rights include:

- The right to choose someone to act for you (i.e., if you have given someone medical power of attorney or if someone is your legal guardian) with respect to the exercising of your rights.
- The right to request restrictions on the use and disclosure of your PHI, including to request that a health plan not be informed of treatment for which you paid entirely out of pocket, which we will say "yes" to unless a law requires us to share that information. For other requested restrictions, note that we are not required to agree to your request, and we may say no if it could affect your care.
- The right to prohibit the sale of your PHI, its use for marketing purposes, or participation in research.
- The right to request to receive confidential communications concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your medical record and other health information we have about you.
- The right to request an amendment or corrections to your medical record. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- The right to receive an accounting of how and to whom your PHI has been disclosed outside of our practice if not for treatment, payment, health care operations, or certain other disclosures (such as any you asked us to make).
- The right to file a complaint if you believe your privacy rights have been violated. You may do so by contacting the Privacy Officer at compliance@usdermpartners.com. You may also file a complaint to the secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling 1-877-696-6775. There will not be retaliation against you for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be in writing and directed to U.S. Dermatology Partners, ATTN: Privacy Officer, 5310 Harvest Hill Rd, Ste. 290, Dallas, TX 75230. Our practice may charge a fee for the costs associated with any request.

E. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you have any questions regarding this notice or our privacy policies, please contact our Privacy Officer at:

U.S. Dermatology Partners
5310 Harvest Hill Rd, Suite 290
Dallas, TX 75230
compliance@usdermpartners.com

Effective Date of Notice: October 10, 2024