PATIENT INFORMATION FOR JOHNSON DERMATOLOGY

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/_____

Legal Name: _____
Last *First* *M.I.*

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female SS# _____

Address: _____
City *State* *Zip*

Preferred Phone: ( ) _____ ☐Home ☐ Cell ☐ Work Email:_____

Employer: _____

(As a result of the American Recovery and Reinvestment Act of 2009, the government has mandated that we request the following information)

Ethnicity: ☐ Latino/Hispanic ☐ Other ☐ Refuse

Race:

☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaskan Indian ☐ Native Hawaiian or Pacific Islander ☐ Refuse

Preferred Language: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address: _____
City *State* *Zip*

Preferred Phone: ( ) _____ ☐Home ☐ Cell ☐ Work

In case of Emergency, who should be notified? _____
Preferred Phone: ( ) _____ Relationship: _____

Do you give our office permission to discuss your medical information with family members?

☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____
Preferred Phone: ( ) _____

Consent to Leave Telephone Message:

I authorize Johnson Dermatology to leave a message containing appointment information(via text, voice or email) and basic medical information, as follows. (I understand that if no selection is made, phone messages will not be left):

Please select your preferred contact number.		**Is it ok to leave a detailed message?**
☐ Contact me at my home.	Phone#_____	☐ YES ☐ NO
☐ Contact me on my cell.	Phone#_____	☐ YES ☐ NO
☐ Contact me at work.	Phone#_____	☐ YES ☐ NO

Primary Care Doctor: _____ Phone: ( ) _____
Were you referred to this office? (If yes, please specify) _____

Pharmacy:_____ Address:_____
Phone: ( )_____

FINANCIAL ARRANGEMENTS

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED IF WE ARE NOT A PARTICIPATING PROVIDER FOR YOUR INSURANCE PLAN.

For your convenience, we offer the following methods of payment. Cash, Check, Visa, M/C, Discover, Amex.

MISSED APPOINTMENTS: Please give 24 hrs. if you are unable to keep your appointment. We reserve the right to bill $50.00 for missed medical appointments and $50.00 missed cosmetic appointments.

RETURNED CHECK FEE: $50.00 OR CURRENT APPLICABLE BANK CHARGE.

PPO INSURANCE PATIENTS: Please check with front desk to see if we are in your plan.

PRIVATE INSURANCE: Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. These services would be your responsibility. We will bill your insurance if we are not a participating provider, but we do require payment in full at the time of the visit.

MEDICARE PATIENTS: All services rendered will be submitted to Medicare for assignment.

AUTHORIZATION AND RELEASE
I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. The undersigned also agree(s) to pay all collection cost incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

X _____ Date _____/_____/_____
Signature of patient or parent if minor

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been offered the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____/_____/_____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

DATE: ____/____/____ INITIALS: _____ REASON: _____