PADUCAH DERMATOLOGY, PLLC

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR THE
PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

PATIENT INFORMATION: (Please Print)

PATIENT NAME: _____
(Last) (First) (Middle) (Maiden)

SOCIAL SECURITY NUMBER: _____ GENDER: Male☐ Female☐

ADDRESS: _____
(Street) (City) (State) (Zip)

PHONE: (_____) _____ CELL PHONE: (_____) _____

DOB:_____ MARITAL STATUS: M S W D

EMAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: (_____)_____

REFERRING PHYSICIAN: _____

GUARDIAN NAME: (IF PATIENT UNDER 18) _____

ADDRESS: _____ PHONE: (_____)_____

IN CASE OF EMERGENCY: (NEAREST RELATIVE NOT LIVING WITH YOU)

NAME: _____

RELATIONSHIP: _____ PHONE: (_____)_____

PRIMARY INSURANCE: _____ PHONE: (_____)_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB: _____ POLICY #: _____ GROUP #:_____

BILLING ADDRESS: _____

SECOND INSURANCE: _____ PHONE: (_____)_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB: _____ POLICY #: _____ GROUP #:_____

BILLING ADDRESS: _____

THIRD INSURANCE: _____ PHONE: (_____)_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB: _____ POLICY #: _____ GROUP #:_____

BILLING ADDRESS: _____

Please provide your insurance card(s) to the receptionist when you register.
It is the policy of Infectious Diseases Associates, PLLC to collect co-payments at time of service. (OVER)

PADUCAH DERMATOLOGY, PLLC

I hereby consent to Paducah Dermatology, PLLC (the "Practice") using or disclosing my protected health information (PHI) for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my PHI for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my PHI in order for assessment and reviewing the competence of health care professionals. The following people are also authorized to receive a copy of my PHI:

SPOUSE/SIGNIFICANT OTHER: _____ PHONE: (_____)_____

OTHER: _____ PHONE: (_____)_____

OTHER: _____ PHONE: (_____)_____

I understand that Paducah Dermatology, PLLC may leave medical/financial information by the following methods: home telephone, home answering machine, cell phone, pager, work telephone, work voice mail.

I request the payment of authorized Medicare benefits and any other insurance benefits be made on my behalf to Paducah Dermatology, PLLC. I authorize any holder of medical information about me to be released to Health Care Financing Administration and its agents for information needed to determine the benefits payable for related services. If covered by a secondary insurance carrier that is a Medigap Carrier, I further authorize payment from the Medigap Carrier to Paducah Dermatology, PLLC for services rendered one year from date of patient signature.

I acknowledge that the Practice has, for public viewing, a copy of its Notice of Privacy Practices and will offer me a copy. This notice provides a detailed description of the users and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Signature of Witness Date

PADUCAH DERMATOLOGY, PLLC

Halden H. Ford, MD Melinda P. Garrett, PA-C

2601 Kentucky Avenue | Suite 402 | Doctor's Building #1 | Paducah, KY 42003
(270) 444-8477 | (270) 444-8479 Fax

Please fill out the enclosed forms and bring them with you to your appointment. We will also need your insurance card and a photo ID that includes your current address. If your current address is not on your driver's license, we will need a copy of a utility or current bill, addressed to you, showing the current address. We will also be taking a photograph at the front desk to be scanned into your medical record; this is for patient protection and to protect against identity theft. If the patient is a minor, we will need this information for the legal guarding bringing the patient in.

The office operates on the same inclement weather schedule as Paducah City Schools.

Patient's Procedures and Rules Policy

If you have **new** information since your last office visit, (name change, address, phone number, or insurance information), please notify the front desk staff when you arrive for your appointment.

It is **your responsibility** to know what procedures are covered by your insurance policy. If your insurance requires referrals to a specialist or a procedure requires being pre-certified (x-rays, CTs, MRIs, etc), please notify one of or staff members **before** the procedure or test is scheduled. If your insurance requires you to go to a particular facility for testing or procedures, please notify one of our staff **before** anything is scheduled. **You** need to contact your insurance company to make sure that our office is an in network provider and any facility that further testing has been scheduled, also. You will need to check your benefits before any testing is done to make sure your tests are covered.

In consideration for those patients who already have scheduled appointments, **please** call in advance to schedule your appointment. This is for your convenience and ours, as the daily schedule fills quickly. If you are over **15 minutes** late to an appointment, you may be rescheduled. If you **no-show three times** in a calendar year, there is the possibility that you could be dismissed from the practice.

Only the patient will be allowed back to the exam rooms, unless it is a child under 18, spouse, or an elderly patient who requires assistance. This allows the doctor to concentrate on the patient, without interruptions from others in the room.

Self-pay patients are required to make payment arrangements or pay in full on the first day of your office visit.

If you have a previous balance on your account, you must pay this amount or have made payment arrangements prior to the office visit. If your insurance requires co-pay, or you have a deductible that has not been met, you will be required to pay that amount on the day of this visit.

We want to **thank you** for allowing us to help you receive the best service that can be provided for you. If you have any questions or a problem with your insurance, we will be glad to help in any way we can.

Thank you,
Doctors and staff

I have read and understand all of the above.

_____ _____

Patient's Signature Date