PADUCAH DERMATOLOGY, PLLC

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

PATIENT INFORMATION: (PLEASE PRINT, COMPLETE BOTH SIDES FRONT AND BACK)

PATIENT NAME: ____
(last) (first) (middle) (maiden)

SOCIAL SECURITY NUMBER (FULL #): ____________________ **SEX:** MALE_____ FEMALE_____

ADDRESS: ____
(street) (city) (state) (zip)

PRIMARY PHONE: (______) ____________________ **OTHER PHONE:** (______) ____________
TYPE: cell / home / work / other TYPE: cell / home / work / other

DOB: ______________________________ **MARITAL STATUS:** M S W D

EMAIL ADDRESS: ____
If an email address is not present, I do not wish to divulge my email address for the sole purpose of registering and participating with this practices Patient Portal services.

EMPLOYER: ____________________ **WORK PHONE:** (______) ____________

GUARDIAN NAME: (IF PATIENT IS UNDER 18) ____________ **DOB:** ____________

ADDRESS (IF DIFFERENT FROM ABOVE): ______________________________
(street) (city) (state) (zip)

IN CASE OF EMERGENCY: **NAME:** ______________________________

RELATION: ____________________ **PHONE:** (______) ____________

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 the disclosure of my PHI for assessment and reviewing the competence health care professionals.
The following people are authorized to receive a copy of my PHI:

Spouse/ Significant Other: ______________________________
(name) (phone)

Other: ______________________________
(name) (relation) (phone)

Other: ______________________________
(name) (relation) (phone)

IT IS THE POLICY OF PADUCAH DERMATOLOGY, PLLC TO COLLECT INSURANCE INFORMATION AND CO-PAYMENTS AT TIME OF SERVICE

(OVER)

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

I request that payment of 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 form 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 uses and disclosures allowed by consent as well as other rights regarding my protected health information.

Medical Records Release Request

I hereby authorize you to release/request all of my medical records or any other information, including any personal or confidential information of a sensitive nature. A photo-stat copy shall be valid as the original authorization. This will not be disclosed to any other person or company without authorization. We will release/request only our physician's records. Includes: Office Notes, Pathology, Laboratory Tests.

This authorization expires 1 (one) year from date signed. I understand this release/request is subject to revocation in writing at any time except to the extent that the program which to make the disclosure has already taken action in reliance to it. I also understand that if the person (s) or entity(ies) that receive the information is not a health care provider or plan covered by general privacy regulations, the information may be disclosed and is no longer protected by these regulations. I understand that I can inspect or request copies with any information disclosed by this restriction.

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.
- Only the patient is allowed back in the exam room unless it is a child under 18, or if the patient requires assistance. This allows the doctor to concentrate on the patient without interruptions from others in the room.
- **A parent or legal guardian MUST accompany a Minor**
- It is your responsibility to know what procedures are covered by your insurance policy. If your policy requires referrals to a specialist or a procedure requires being pre-certed (x-rays, CT's MRIs, etc.) please notify one of our 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 as well as any other facility where further testing has been scheduled. You will need to check your benefits before any testing is done to make sure your tests are covered.
- Self-pay patients are required to pay in full (at the quoted price) at check-in.
- Patients who have a balance due, must pay this amount or have made payment arrangements prior to the office visit. If your insurance requires a co-pay, or you have a deductible that has not been met, you will be required to pay that at check-in.
- When you schedule an appointment with Paducah Dermatology, we set aside time to provide you with quality care. Should you need to cancel or reschedule an appointment please contact the office as soon as possible (270-444-8477). **Effective April 1, 2023 any patient that fails to show for their appointment or fails to cancel an appointment without contacting our office 24-hours or more before the appointment will be charged a fee. This fee is charged to the patient, not the insurance company, and is due before another appointment can be scheduled.** As a courtesy we provide reminders via phone calls, text and/or email. If you do not receive a reminder, the policy is still in effect.
- **All general dermatology appointments a 24-hour notice of cancellation and have a $25 No-show Fee. Surgical appointments, with Dr. Joseph Blackmon, require 48-hour notice of cancellation and have a $100 No-show Fee. Surgical follow-ups with Dr. Joseph Blackmon require a 24-hour notice of cancellation and have a $25 No-show Fee**
- **In consideration for those patients who already have scheduled appointments, please call us in advance to schedule your appointment. If you are over 15 minutes late to an appointment you may be rescheduled. If you no-show 3 times within a calendar year, there is a possibility that you could get dismissed from the practice.**
- We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager.

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.

I have read and understand all of the above.

Patient's signature: ____ **DOB:** ______________________ **Date:**__________