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: _____SEX: Male_____ Female_____

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

PHONE: (_____) _____CELL: (_____) _____

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 practice's Patient Portal Service.

EMPLOYER:_____WORK PHONE: (_____)_____

REFERRING PHYSICIAN: _____PRIMARY CARE PHYSICIAN (PCP):_____

GUARDIAN NAME: (IF PATIENT UNDER 18)_____

ADDRESS: _____PHONE: (_____)_____

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

NAME: _____

RELATION: _____PHONE: (_____)_____

PRIMARY INSURANCE: _____PHONE: (_____)_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB:_____POLICY NO.:_____GROUP NO.: _____

BILLING ADDRESS:_____

SECONDARY INSURANCE: _____PHONE: (_____)_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB:_____POLICY NO.:_____GROUP NO.: _____

BILLING ADDRESS:_____

THIRD INSURANCE: _____PHONE: (_____)_____

CARDHOLDER NAME & RELATION TO PATIENT: _____

DOB:_____POLICY NO.:_____GROUP NO.: _____

BILLING ADDRESS:_____

It is the policy of Paducah Dermatology, PLLC to collect co-payments at time of service. (OVER)

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_____

Name Phone Number

Other _____

Name Phone Number

_____

Name Phone Number

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 that 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 uses 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