

PATIENT INFORMATION FORM

Chart # _____

Date _____ New Patient _____ Information Update _____ (please check one)

DEMOGRAPHICS:

Last Name _____ First Name _____ MI _____

SEX: _____ M _____ F Date of Birth: ____/____/____ SSN: _____ - _____ - _____

Street Address _____ Apt./Unit # _____

City _____ State _____ Zip Code _____ - _____ Primary Ph#() _____

Spouses Name _____ Parent/Guardian Name _____

Name of Employer _____ Occupation _____ Secondary Ph#() _____

MEDICAL INFORMATION

Referring DR. _____ Street Address _____

City _____ State _____ Zip Code _____ - _____ Office Ph#() _____

Reason for this Visit? _____

Other Medical Conditions? _____

Drug Allergies? _____ Other Allergies? _____

Current Medications: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Phone #: _____

Claims Address: _____

Policy Holders Full Name: _____ Date of Birth: ____/____/____

Policy Holders SSN: _____ - _____ - _____ Relationship to Patient: _____ Employer: _____

ID#: _____ Group #: _____

Secondary Insurance: _____ Phone #: _____

Claims Address: _____

Policy Holders Full Name: _____ Date of Birth: ____/____/____

Policy Holders SSN: _____ - _____ - _____ Relationship to Patient: _____ Employer: _____

ID#: _____ Group #: _____

MEDICAL RELEASE

Current textbooks of Dermatology recommend that all patients coming to a Dermatologist's Office, *no matter what reason*, have a total body skin examination for *any possible skin cancers*. Therefore, if you **DO NOT** want a total body skin exam done, please sign below, releasing Dr. Albert from any and all responsibility for all conditions and tumors that are **not found** because the skin was not examined.

X _____
Signature of Patient Date

PATIENT RESPONSIBILITY AGREEMENT

Please initial each line after reading.

I understand that, I must provide my insurance card each visit, before seeing the doctor, regardless of when my last visit was; _____

I understand that, if I have an outstanding balance I must pay it off before being seen by the doctor; _____

I understand that, if I fail to cancel/reschedule my appointment 24 hours in advance I will be charged \$35 for an office visit/follow up appointment or \$100 for a cosmetic/surgery appointment; _____

AUTHORIZATION FOR RELEASE OF MEDICAL AND INSURANCE INFORMATION

I authorize Moses K. Albert, M.D. to apply for benefits on my behalf for covered services. I authorize Dr. Albert to release any medical information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to Moses K. Albert, M.D.

I authorize that a photocopy of this form can be used in place of the original.

I understand that Moses K. Albert, M.D. will apply for the maximum benefits of covered services from insurance. I am aware that I am financially responsible for all co-payments, deductible, and other amounts deemed appropriate by my insurance company. I am aware that all non-covered procedures and services are my responsibility and agree to pay for these services. I am aware there will be a fee \$35.00 for a returned check and a 25% service charge for delinquent accounts that are sent for collections.

I authorize Dr. Moses K. Albert to examine and treat me.

X _____
Signature of Patient or Responsible Party Date

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, Moses K. Albert, M.D., P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ³ A basis for planning my care and treatment
- ³ A means of communicating among the many health professionals who contribute to my care. I give Moses K. Albert, M.D. permission to send my medical records to my referring physician and to any physician to whom Dr. Albert refers me for medical care, in order and for the sole purpose of providing optimal medical care to me.
- ³ A source of information for applying my diagnosis and surgical information to my bill.
- ³ A means by which a third-party payer can verify that services billed were actually provided.
- ³ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ³ The right to review the notice prior to signing this consent
- ³ The right to object the use of my health information for directory purposes, and
- ³ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Moses K. Albert, M.D., P.C. is not required to agree with restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Moses K. Albert, M.D., P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Moses K. Albert, M.D., P.C. change their notice, they will send a copy of the revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and *accept/decline* the terms of this consent.

X _____
Patient's Signature

Date

