SENTER DERMATOLOGY - PATIENT DATA SHEET – PLEASE PRINT

*****Please Note*** If this form is not filled out completely, we will not be able to submit to your insurance.**

Today's Date: _____/_____/_____ Patient Date Of Birth: _____/_____/_____

Patient Name: _____ _____ _____
FIRST M.I LAST

Gender: ☐ **Male** ☐ **Female** Marital Status: ☐ **D** ☐ **M** ☐ **S** ☐ **W**

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Home Number: _____ Work Number: _____ Cell Number:_____

****** MAY WE LEAVE MESSAGES WITH MEDICAL INFORMATION AT THE NUMBERS LISTED ABOVE? ☐ Yes ☐ No ******

SSN# _____*required for insurance submission * Email address: _____

Occupation: _____Employer:_____

Emergency Contact & relation to patient: _____ Contact Number: _____

Any family members who are patients here? If so, please list: _____

Who is responsible for this account? _____ Contact Number(s): _____

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Please list the name(s) and phone number(s) of all those that you give us permission to speak to regarding your care here:_____

_____

MEDICAL HISTORY

Are you allergic to any medications? ☐ **Yes** ☐ **No** Any other Allergies? ☐ **Yes** ☐ **No**

If yes, please list: _____ If yes, please list:_____

_____ _____

_____ _____

Are you taking any medications? (Prescribed/Over the Counter) ☐ **Yes** ☐ **No** If yes, please list: _____

_____

_____

_____

What is your preferred Pharmacy? _____ Location: _____

Who is your Primary Care Physician? _____ Contact Number:_____

Are you seeing any other Physicians at this time? If so, please list: _____

_____

General medical history:

_____

_____

_____

_____

_____ Relationship to Patient:_____
SIGNATURE

For our office to provide the best medical care for our patients, we ask that you acknowledge and adhere to the office policies listed below.

****PLEASE INITIAL EVERY LINE TO ACKNOWLEDGE EACH STATEMENT****

PATIENT RESPONSIBILITIES

_____ If more than three appointments are missed, or if you fail to contact our office in a timely fashion to cancel an appointment, the provider may decide to discontinue seeing you at this office.
_____ It is the responsibility of the patient to respond to mailed or phone requests for follow up. Failure to respond in a timely manner to mailed or phone messages regarding your follow up may result in your discharge from this practice.

BILLING POLICIES

It is the responsibility of the patient to:
_____ Provide accurate and complete insurance information.
_____ Contact the insurance company if a claim is thirty days or more past due.
_____ Pay all outstanding balances after sixty days, regardless of whether or not the insurance has made a determination on the claim.
_____ Promptly pay any balance remaining after the insurance finalizes the claim.
_____ Promptly respond to any questionnaires or updates sent out by the insurance company regarding coverage so as not to delay claim payment. If the patient fails to supply an insurance company with requested information, the account will be turned over to a collection agency immediately.

BILLING INFORMATION

_____ We are not accepting new patients on Medicare or Medicaid, and are not an authorized Tricare provider, nor do we participate in Workman's Compensation claims. We ask for payment at the time of your visit. We accept cash, check, MasterCard or Visa.
_____ Senter Dermatology is a preferred provider with Blue Cross, Aetna, Cigna & Multiplan. If you have questions regarding in network insurance benefit levels, please contact your insurance provider.
_____ As a courtesy to our patients, we will submit to insurance. In some cases, patients are required by their insurance company to submit themselves. If this applies to you, we will provide you with the appropriate paperwork.
_____ If there is a patient balance more than sixty days past due after a visit and the insurance company has finalized, we will charge interest on this amount.
_____ If a patient does not assist our office in settling claims, we reserve the right to stop billing insurance on any future visits, and turn the account over to an outside collection agency.

INSURANCE INFORMATION

If you do not have the following information readily available at the time of your visit you will be asked to pay your visit in full. Please present card to front desk.

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Identification Number: _____ Insurance Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

Subscriber Social Security Number: _____ Subscriber Contact Number: _____

Subscriber's Relationship to the Patient: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT/GUARDIAN** ☐ **OTHER**_____
Please Specify

I attest that the above information is accurate and I understand Senter Dermatology's office policies.

X: _____ _____ _____/_____/_____
Signature Printed Name Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

USES AND DISCLOSURES OF HEALTH INFORMATION TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Senter Dermatology uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

-Sharing test results with other health care provider for confirmation of diagnosis;
-Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
-Reviewing information as part of our quality improvement program.

Other Uses and Disclosures

Senter Dermatology may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

-Provide you with information related to your health;
-Contacting you regarding appointments, information about treatment alternatives, or other health related services;
-Incidental uses or disclosures (e.g., listing your name on a sign in sheet, etc.);
-Compliance with all laws (including reports of suspected abuse, neglect or violence);
-Providing certain specified information to law enforcement or correctional institutions;
-Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
-Public health activities when requested by public health authority or the FDA;
-Responding to health oversight agencies;
-Responding to court or administrative tribunal orders, subpoenas, discover request or other lawful process;
-Research activities;
-When necessary to avert a serious threat to health or safety;
-Military affairs, veterans' affairs, national security, intelligence, Department of State, or presidential protective service activities;
-Providing information regarding your location, general condition or death to public or private disaster relief agencies;
-Informing a family member, other relative or close personal friend when: Information is relevant to the individual's involvement with your care;
-To assist in your health care (e.g. pick-up prescription or other documents, note follow up care instructions, etc.).

Authorization for Other Uses

Senter Dermatology will make other uses or disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice you may revoke your authorization.

Your Rights Regarding the Privacy of your Health Information

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

-Request restrictions on certain uses or disclosures. However, Senter Dermatology is not obliged to agree to requested restrictions.
-Receive confidential communications of protected health information.
-Inspect and copy your protected health information with some limited exceptions.
-Amend your health information.
-Receive an accounting of disclosures of your health information.
-Obtain a copy of this notice.

Senter Dermatology Regarding the Privacy of your Health Information

Subject to limitations outlined by law, Senter Dermatology has certain duties related to your protected health information, including:

-Senter Dermatology is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Senter Dermatology is required to abide by the terms of the privacy notice that is currently in effect.
- Senter Dermatology reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacted Senter Dermatology or the Secretary for the Department of Health and Human Services. NO individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I received a copy of this notice regarding the use and disclosures of my health information.

X: _____ _____ _____/_____/_____

Signature Printed Name Date