|  |  |  |
| --- | --- | --- |
| **Last Name**  | **First Name** | **Middle Name** |
| **Birth Sex** **M / F** | **Gender Identity/Pronouns** | **Birth Date** | **Email** | **Social Security #** |
| **Billing Address** | **Unit** | **City, State** | **Zip Code** |
| **Home Phone** | **Work Phone** | **Cell Phone** |
| **Emergency Contact Name** | **Emergency Contact Number** | **Relationship** |
| **Primary Care Physician Name** | **Primary Care Physician Phone #** | **Were you Referred?**Yes/ No | **Referred By** |
| Guarantor/Legal Guardian **(complete only if different than above)** |
| **Last Name**  | **First Name** | **Middle Name** |
| **Sex** | **Date of Birth** | **Social Security #** |
| **Street Address** | **Unit** | **City, State** | **Zip Code** |
| **Home Phone** | **Work Phone** | **Cell Phone** |

**Financial Policies:**

**Medical appointments**: Up-to-date insurance information is required to schedule appointments. Modern Dermatology is contracted with most commercial insurance plans. If you are uninsured or have a plan that Modern Dermatology is not contracted with, payment in full is expected at the time of service.

Co-pays are due at the time of service. You agree to assign payment directly from your insurance to Modern Dermatology. You are financially responsible to Modern Dermatology for the charges not paid by your insurance company and understand that those charges are due within 30 days of invoice. In addition to the bill from your provider at Modern Dermatology, you may also receive separate bills from the pathology laboratory and/or other specialized services.

**Referral Policy**: You are responsible for all referrals/ authorizations required to comply with your insurance plan. When required, you must obtain this prior to your scheduled appointment. If your claims are denied for lack of referral/ authorization or if the referral/ authorization is rejected by your insurance company, it is possible that you may not be able to be seen at Modern Dermatology. *In some cases, you may have the option to pay out of pocket on the day of service and will be responsible for all charges incurred.*

**Missed Appointment Policy:**

 The purpose of this policy is to ensure that any cancellations or appointment modifications are made with adequate time

 for other patients to be seen during the time we had reserved for you.

**Medical**: Modern Dermatology requires 48 business hours’ notice of any changes or cancellation of any medical appointments. If you reschedule, no show or cancel your appointment within 48 business hours, you will be required to pay $50.00. If a third late cancellation, reschedule or no show should occur, within the same calendar year, you will either be discharged from the practice, or the cancellation fee will increase to $150.00. This amount is due before scheduling any future appointments.

**Aesthetic:** Modern Dermatology requires 48 business hours’ notice of any changes or cancellation of any aesthetic appointments. If you make changes to your treatment plan, reschedule, no show or cancel your appointment within 48 business hours, you will be required to pay $250.00. If a third late cancellation, change to your treatment plan, reschedule or no show should occur, within the same calendar year, you will be required to pay 50% of the service you are requesting to reserve any future appointments. This amount is non-refundable should you fail to show up or cancel within 48 business hours of your appointment.

 **\_\_\_\_\_\_\_\_\_\_\_ Initials**

**Disclosure Authority**

I understand the risks involved with using unencrypted email and disclosure of Protected Health Information through use of unencrypted email. I choose to communicate with Modern Dermatology using (please make ONE selection)

 \_\_\_\_\_\_\_\_\_\_\_Unencrypted Email (most common) \_\_\_\_\_\_\_\_\_Encrypted Email (may require username and password)

*If both or neither option is selected, then the default is to communicate using unencrypted email.*

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my ALL my Protected Health Information in my medical record including x-rays, bills etc. as indicated below:

 \_\_\_\_\_\_\_\_\_\_\_Self \_\_\_\_\_\_\_\_\_Partner \_\_\_\_\_\_\_\_ Other individuals

|  |  |
| --- | --- |
| Partner’s Name | Partner’s Date of Birth |
| Other Individual | Relationship to Patient |
| Other Individual | Relationship to Patient |

I authorize MD staff to leave a detailed voice message with the home number on file Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

I authorize MD staff to send text message reminders to the phone number on file Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

*If both or neither option is selected, then the default is messages are authorized.*

**Consent to Care:**

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known.

**Notification of Release of Payment:**

I understand that Modern Dermatology will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment of HIV/ AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

**Receipt of Notice of Privacy Practices:-Please see the following page**

I have reviewed Modern Dermatology’s Notice **of Privacy Practices** which provides additional information about how my health information may be used and disclosed.

I have read and understand its contents:

**Signature of Patient or legally authorized individual**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_

**Printed name *if signed on behalf of the patient***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent, legal guardian, personal representative)

**NOTICE OF PRIVACY PRACTICES**

At Modern Dermatology, we are required by law to protect the privacy of your information, to provide this notice about our privacy practices, and follow the privacy practices that are described in this notice.

This notice describes how your health information may be used and disclosed. It also describes how you can get access to this information. Please review this notice carefully. Your information may be used to contact you about appointments, provide test results, inform you about treatment options, or advise you about any health-related services and benefits. You have the right to request in writing that we contact you by alternative means or locations.

Modern Dermatology keeps a record of the health care services we provide you. You may ask to review and/or obtain a copy of that health information. At any time, you may ask us to correct that heath information. This Notice provides detailed information about how we may use and disclose your health information with or without authorization as well as more information about your rights as a patient with respect to your health information. You may contact our office at any time and request to speak with our Privacy Officer, Wendy Hurst @ 206-489-2530 for more information on how to exercise these rights or to make a complaint. You may be required to submit your request in writing. We may provide the information in electronic format. If you request a copy we may change a fee for the costs of copying, mailing, or other supplies associated with your request.

You have the right to request in writing an amendment to your health information and we may agree that it is wrong and/or incomplete. We may deny your request in certain situations, such as when the health information is accurate and complete. You will receive any denials in writing. You have the right to appeal our denial by filing a written statement of disagreement. You may revoke any written authorization to use or disclose heath information except to the extent that we may have already acted.

We are permitted to disclose information to notify: a family member, personal representative, or another person responsible for your care of your location in our office and your general condition. Unless you notify us in writing that you object, Modern Dermatology will also use its best judgment to disclose your health information to a family member, other relative, personal representative, close personal friend, or other person you have identified that is relevant to the person’s involvement of or payment for your care. Even if you are not present or available, Modern Dermatology is permitted to make such disclosures if they are in your best interest.

In order for us to obtain payment for the services provided at Modern Dermatology, we may disclose your health information to the party or parties responsible for paying. This may include your Insurance Company and/or Medicare. Your insurance company/plan may require documentation of your health information to make such determination as your eligibility for coverage, or in reviewing the medical necessity of services provided to you. Your information may also be disclosed for treatment. Treatment is defined as providing and arranging for any health-related services with other providers. This may also include coordinating your care with at third party, obtaining a consultation from another provider, or making a referral.

We may use your health information when required by law or to prevent a serious threat.

Other miscellaneous Uses or Disclosures of Your Health information when Authorized by Law:

* To public health authorities when information or communicable diseases, HIV/AIDS, vital records, or acts of violence or at-risk behaviors. This includes disclosing your health information to a person who may have been exposed or may be at risk for contracting or spreading a disease/condition;
* To a school regarding your proof of immunization;
* To the FDA about related drugs and/or devices;
* To applicable government agencies or law enforcement when we suspect neglect or abuse;
* To a compliance officer or heath oversight agency for any investigations, audits, inspections, and licensure;
* To a court or administrative order, including but not limited to a subpoena;
* To law enforcement coroners, medical examiners, funereal directors, and organ procurement activities;
* To a correctional institution if you are an inmate or under custody;
* To trauma registries;
* To a public or private entity including the Red Cross or FEMA to assist in disaster relief efforts so that your family and friends can be notified about your condition, status, and location.

You have the right to be notified by us if we discover a breach of your unsecured health information according to the requirements of both federal and state law,.

Modern Dermatology reserves the right to change our Notice of privacy Practices. New Notice provisions will be effective for all protected health information that we maintain. You may request to review a copy of our most current Notice at any time.