# Demographics and Consent Form

Name:_______________________________________ Age:_____ DOB:________ Sex:_____

Address:_______________________________________ Please complete if applicable:

City/State:_______________________________________ Spouse / Partner:_______________________________

Zip:__________ SSN:______________________ SSN:________________ DOB:__________

Home#:_________________ Cell:__________________ Employer:______________________________

Work#:_______________________________________ Phone:______________ Cell:______________

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**Emergency Contact**:______________________________ Relationship:___________________________

Home#__________________________________ Work#_______________________ **Cell#**________________________

Primary Care Doctor. _________________________Referred by Doctor________________________________________

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**Acknowledgement of Receipt of Privacy Notice**

I have been presented with a copy of **Pennsylvania Centre for Dermatology, LLC'**s Notice of Privacy Policies (effective date February 1, 2006) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Signed:________________________________ Date:_______________________

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**Payment Agreement**

Medicare Patients:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me at the Pennsylvania Centre for Dermatology, LLC including physician services. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related service.

All Patients:

**PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES**. I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, and Visa / Mastercard. I understand that there will be a twenty five dollar fee for appointments not kept and appointments cancelled with less than twenty four hours notice. I also understand that there will be a thirty five dollar fee for all returned checks. Your signature below indicates that you accept these policies. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Signature of Patient or Legal Guardian:______________________________ Date:__________________________

Patient relationship to policy owner: ☐ Self ☐ Child ☐ Spouse ☐ Other______________

Should my account fall into arrears greater than 60 days, I authorize that unpaid balances be charged to my major credit card as listed:

☐ Visa ☐ Masterdcard Card#________________________________ Exp. Date:______________________

Name on Card_______________________________ Signature_______________________ Date_____________

## Consent for Treatment and Release of Medical Information

I authorize treatment and/or services to myself or minor child at Pennsylvania Centre for Dermatology, LLC. I authorize Pennsylvania Centre for Dermatology, LLC, to release information requested by my insurance company or any of its agents. I also authorize Pennsylvania Centre for Dermatology, LLC, to furnish my primary care physician, referring physician or other treating medical professional any and all information that may be requested regarding my physical or mental condition and treatment rendered there fore and, if necessary, to allow them or any physician appointed by them to examine any records or results regarding my treatment. This authorization shall remain in force until revoked in writing by the undersigned.

Signed (patient or responsible party):___________________________________ Date:_________________________

(If minor or other responsible party signs) Staff member witness: Name_____________________ Signed________________

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## Consent for Communication of Information

In addition to release of information as authorized in the Authorization to Release Medical Records on the prior page, and in the interest of confidentiality, and compliance with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgement as to whom we may release information on your behalf is required.

I authorize the release of information as it pertains to my care only to the following individuals:

- ☐ Name:___________________________________ Relationship:___________ Tel#__________________________________________
- ☐ Name:___________________________________ Relationship:___________ Tel#__________________________________________
- ☐ Name:___________________________________ Relationship:___________ Tel#__________________________________________

For the purposes of communicating test results, prescription refill requests, and other protected health information, I authorize my physician and/ or his/her designee to utilize the following mechanism/s:

- ☐ On my home answering machine (#____________________________________)
- ☐ On my cell phone message system (#___________________________________)
- ☐ On my office voice mail (#_____________________________________)
- ☐ Via email (email address_________________________________________________________________________________)

**(For security and privacy reasons, your physician will not respond to unsolicited email communications)**

I have the right to revoke and change my consent options as listed above. When circumstances change regarding my response, I will submit written changes, revocation, limitations, and restrictions to the Pennsylvania Centre for Dermatology, LLC, at the current address. Your physician and the Pennsylvania Centre for Dermatology, LLC, will not be held liable for communication of protected health information via the consented option(s) above without an updated written consent form.

Signed:___________________________________ Date:_________________________

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Internal Use Only:

If the patient or patient's representative refused to sign any of the above acknowledgements, please document the date and time the patient was presented with the above material and sign below:

Information presented on (date)________________________________ Time:________________________

Staff Name:_______________________________________ Signature:__________________________________________