

# HIPAA

## Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

### Acknowledgement of Notice of Privacy Practices

My signature below verifies that I, \_\_\_\_\_, have received  
(Print Name)

a copy of the Notice of Privacy Practices from Romagosa Dermatology Group, LLC

Signature of Recipient \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Protected Health Information Authorization

My signature below indicates that I  **DO** /  **DO NOT** (please check one) authorize Romagosa Dermatology Group, LLC to discuss my PHI with my spouse or personal representative.

If yes, please provide their name and phone number.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship : \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Patient Registration Form

Name: \_\_\_\_\_  Jr  Sr  Dr  
First Middle Last

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_  Hispanic  Non-Hispanic  Decline

E-Mail address: \_\_\_\_\_

Is it okay to email you about upcoming cosmetic promotions and events (your e-mail will not be shared with any outside parties)? **Yes** or **No**

**Primary address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

Home #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

**Secondary address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

Home #: (\_\_\_\_) \_\_\_\_\_

**Insurance Information:** Do you have health insurance?  Yes  No (if yes, please complete below)

**Primary Insurance Carrier:** \_\_\_\_\_ Policy type:  PPO  HMO

Address: \_\_\_\_\_

Name of Insured (Guarantor): \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy #: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_ Policy type:  PPO  HMO

Address: \_\_\_\_\_

Name of Insured (Guarantor): \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy #: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

## Emergency Contact (In Case of Emergency)

Name of Spouse/Close Relative or Friend: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Name of Spouse/Close Relative or Friend: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

**Please present your insurance card(s) and your photo ID to the receptionist along with this completed form. The receptionist will make a copy and return them to you promptly. Thank You.**

## PLEASE READ AND SIGN

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a pre-paid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a \$10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Romagosa Dermatology Group, LLC  
Medical History and Intake Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Past Medical History:** (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood pressure	Stroke
COPD	HIV/AIDS	
Coronary Artery Disease	High Cholesterol	
	Thyroid Problems	NONE

Other : \_\_\_\_\_

**Past Surgical History:** (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	

NONE

Other: \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other: \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

Romagosa Dermatology Group, LLC  
Medical History and Intake Form

Do you wear Sunscreen? Yes No  
If yes, what SPF? \_\_\_\_\_  
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No  
If yes, which relative(s)? \_\_\_\_\_

**Medications:** (Please enter all current medications)

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**Allergies:** (Please enter all allergies)

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**Social History:** (Please circle all that apply)

**Cigarette Smoking:**

Currently Smokes  
Has smoked in the past  
Never smoked  
Former Smoker

**Alcohol Use:**

EtOH- None  
EtOH- less than 1 drink per day  
EtOH -1-2 drinks per day  
EtOH -3 or more drinks per day

Other: \_\_\_\_\_

Family History (Only first degree relatives)

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Preferred Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_

Preferred pharmacy Name: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

Pharmacy City or Zip code: \_\_\_\_\_

**ALERTS:** (please circle all that apply)

Allergy to Adhesive  
Allergy to lidocaine  
Allergy to topical antibiotics  
Artificial heart valve  
Artificial joint replacement  
Blood thinners

Defibrillator  
MRSA  
Pacemaker  
Require antibiotics prior to a surgical procedure  
Rapid heartbeat with epinephrine  
Pregnant or currently trying to get pregnant?

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

To Our Patients:

As you know if you have ever checked into a hotel or rental car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Romagosa Dermatology Group, LLC

I authorize Romagosa Dermatology Group, LLC to charge outstanding balances on my account to the following credit card:

Visa    MasterCard    American Express    Discover    Other: \_\_\_\_\_

Account number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on card (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

optional