

Patient Personal Information

Patient Full Name:

Date of Birth: Male Female

Marital Status: Minor Single Married Divorced Widowed Other

Home Address:

City: State: Zip:

Mailing address:

City: State: Zip:

Preferred Pharmacy:

Preferred Pharmacy City: Street:

Patient Contact Information

Cell #: Home #: Work #:

Which is the best number to reach you ? Cell Home Work

Preferred Appt Reminder Method? Text Email Phone Call: Cell Home

Email:

In case of emergency who should we contact?

Name: Relationship:

Work #: Home #: Cell #:

Physician Referral Information

Referred By:

Primary Care Physician:

Signature

Print Name:

Patient / Parent / Legal Guardian (please circle relationship)

Signature:

Date:

OFFICE USE ONLY

Current Ins Card on File 20_____

Redwood Family Dermatology
ePrescribing consent

ePrescribing is a federally mandated initiative by the Center for Medicare and Medicaid Services (CMS) that requires all physicians prescribe in this manner.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software allows your physician to see important information, like drug interactions and your prescription history.

By signing the consent below, you will benefit from a safer, faster and easier way to get your prescriptions filled.

I agree that **Redwood Family Dermatology** may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient's Signature _____ Date _____
Signature of Patient or Responsible Party

Patient's Name (Please Print) _____
First Name Last Name

Expiration Date: Unlimited, unless otherwise indicated _____
Other date

Redwood Family Dermatology Financial Policy

We are committed to providing you and your family with the best possible care. In order to achieve this, we ask for your cooperation with our Financial Policy. Please read over the details of this policy carefully.

- For uninsured patients, payment is expected at the time of service.
- A copy of your insurance card(s) and you ID will be made for your chart. Your copayment is due at the time of service.
- If your health plan requires a prior authorization to see a specialist, you are required to obtain the prior authorization before obtaining medical services with the specialist.
- Your insurance is a contract between you, your employer (if applicable) and your insurance company. You are responsible for payment of any deductible, copay or coinsurance your insurance applies to your claim.
- It is your responsibility to inform us of any changes in your insurance coverage.
- As a courtesy, we will submit a claim to your insurance on your behalf.
- Your health plan or Medicare may not cover some or all of the services provided. Services denied as not a covered benefit, deemed not medically necessary or deemed cosmetic by the insurance company are the responsibility of the patient.
- Payment for cosmetic products and/or cosmetic services is required to be paid in full at the time of service.
- Procedures done in our office are under the heading of "surgery" by all insurances companies. You likely will receive an explanation of benefits showing you had "surgery" with our office.
- Dermatology does not fall under "preventative services" by insurance companies as Dermatology visits are based on a diagnosed problem.
- There is a \$25 charge for checks returned for non-sufficient funds.
- Timely payment of your balance is required. Your balance is due upon receipt of your statement.

Assignment of benefits:

I hereby give authorization for payment of Medicare/Health Plan befits to be made directly to Redwood Family Dermatology for services rendered. I authorize Redwood Family Dermatology to release all necessary information to secure befit payments. I agree a photocopy of this agreement shall be valid as the original.

Signature of Patient or Responsible Party

Date

Patients Name (Please print)

REDWOOD FAMILY DERMATOLOGY

**PATIENT RECORD OF DISCLOSURES AND
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Primary Telephone: _____

O.K. to leave message with detailed information on answering machine

Leave message with call back number only

Discuss your medical condition with any member of your home? YES NO

With whom may we discuss your medical condition? _____

Work Telephone:

O.K to leave message with detailed information

Leave message with call back number only

Written Communication:

Mail to my home address

Mail to my work/office address: _____

O.K. to fax to this number: _____

Please note, it is the patient's responsibility to inform our office of any change of information.
My signature below also acknowledges that I have received the Notice of Privacy Practices

Signature of Patient/Parent/Legal Guardian/Personal Representative (Please Circle)

Print Patient's Name

Print Your Name

Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosure made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosure. (Note: Uses and disclosures for treatment, payment or operations (TPO) are permitted without consent.)

Record of Disclosures of Protected Health Information

Date	Disclosed to whom (address or fax)	Authorized in writing	Description of disclosure	Disclosed by whom	Reason	How disclosed*

*Fax, Telephone, E-Mail, Mail or Other