


DARABI
DERMATOLOGY

Patient Information Form

(Rev. 1/3/2022 – GM)

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Social Security #: _____ Sex: M / F / Other: _____

Race: Asian Black Hispanic White Decline to Specify

Ethnicity: Latino Non-Latino Decline to Specify

Language: English Spanish Other: _____ Decline to Specify

Marital Status: Single Married Divorced Widowed Other: _____

Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Preferred Contact Method: Phone Text Email

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

Primary Care Provider: _____ Town / Facility of Practice: _____

Referring Provider: _____ Town / Facility of Practice: _____

How did you hear about us? Provider Referral Internet Billboard Word of Mouth Print Ad Previous Patient Other

Primary Insurance Carrier: _____ Relationship to Subscriber: Self Spouse Child Other

Policy / ID Number: _____ Group Number: _____

Subscribers Name (If Not Self): _____ Subscriber's Date of Birth (If Not Self): _____

Secondary Insurance Carrier: _____ Relationship to Subscriber: Self Spouse Child Other

Policy / ID Number: _____ Group Number: _____

Subscriber's Name (If Not Self): _____ Subscriber's Date of Birth (If Not Self): _____

Signature: _____ **Today's Date:** _____


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General Consent and HIPAA Form

(Rev. 7/23/2022 – KD)

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include lab tests, procedures such as biopsies and destructions, and other diagnostic tests. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatment, tests, and procedures and that I have the right to refuse his/her recommendations.

BILLING AUTHORIZATION: I hereby authorize Darabi Dermatology to release requested medical information to my insurance company to collect payment for any charges.

ASSIGNMENT OF BENEFITS: I hereby request that payment of insurance benefits be made directly to Darabi Dermatology on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to services for myself or my dependent. It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay any balances promptly.

MEDICARE AUTHORIZATION: I request the payment of authorized Medicare benefits be made on my behalf to Darabi Dermatology for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as noncovered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those services rendered.

FINANCIAL POLICY: I acknowledge that I had access to a copy of the financial policy of Darabi Dermatology in the practice and on the practice website and have been able to review the policy. I know that any co-pay is due at the time of service. I am familiar with Darabi Dermatology policies on insurance benefits, claims, referrals, precertification, lack of insurance, finance charges, past due balances, no-show/late cancellation fees.

PATIENT'S RIGHT TO PRIVACY: I acknowledge I have been made aware of Darabi Dermatology's HIPAA Privacy Practices that pertain to my rights regarding the use and disclosure of my protected health information. These rights are more fully described in this office's Notice of Privacy Practices available to me on the practice website and in the clinic. I consent to be contacted by Darabi Dermatology or other business associates at the physical address, phone numbers and emails provided.

BLOOD TESTING: I understand that while receiving care, a healthcare worker may accidentally be exposed to my blood or other bodily fluid. In this rare event, I consent to my blood be tested for the presence of infectious diseases to protect the worker. Some of my test results may be reportable to public health agencies and to the exposed worker and clinic employees for prophylactic treatment of the worker.

ELECTRONIC PRESCRIBING: I authorize Darabi Dermatology to retrieve my medication history from my pharmacy through their e-prescribing system and then import my current medications into my electronic medical record.

PHOTOGRAPHY: I consent to my image and voice be recorded for medical records and communication with other health care providers involved in my care. My recordings may be used in publications and marketing materials with every attempt made to conceal my identity and I do not request compensation or royalties.

Sharing of Protected Health, Personal & Financial Information

I authorize Darabi Dermatology to discuss **all aspects** of my protected health information including but not limited to appointments, medical diagnoses, tests results, prescription information and financial information with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Contact Preferences

I wish for Darabi Dermatology to contact me and leave a detailed message with Protected Health Information at the following numbers:

(If you select "No" we would only leave a message stating that we are calling from Darabi Dermatology and ask to return our call.)

Cell Phone Number: Yes No

Home Phone Number: Yes No

Work Phone Number: Yes No

Other: _____ Yes No

Signature: _____ **Name (Print):** _____ **Today's Date:** _____



Secure Payment Card on File Policy

(Rev. 7/23/2022 -KD)

Darabi Dermatology requires all patients to keep a credit or debit card on file to pay any out-of-pocket balance due after insurance has made payment to us, or for self-pay patients. After your visit, we will submit a claim to your insurance and await insurance payment. After we receive payment from your insurance and if insurance leaves a portion for you to pay, we will send you a statement for your out-of-pocket responsibility (deductible, co-insurance) and await your payment. If no payment is received 20 days after the date of the statement, we will charge the card on file the outstanding balance due. This card will be used only to charge any remaining balance due on the patient's account (co-payments, co-insurance amounts, deductibles, no-show/cancellations with less than 24 business hours notice fees, returned check fees, interest charges for overdue payments, payment plan installments and other fees listed in our Financial Policy and General Consent).

If you do not have a credit or debit card, we would require a check for \$200 made out to Darabi Dermatology to be kept on file.

Itemized receipts will be sent to you for any charges made to your credit or debit card.

We do not physically store your card information on paper or on our computers and we only see the last 4 digits of your card. Your card information is kept on file securely with Modernizing Medicine, our cloud-based third-party HIPAA and PCI compliant electronic practice management software provider.

Please provide your credit or debit card to the front desk staff to enter into your electronic chart.

Thank you.

By signing this form, I authorize Darabi Dermatology to charge co-pays and any outstanding balances on my account to the credit card, debit card, or check kept on file.

Signature: _____ Name (Print): _____

Today's Date: _____ Staff Witness: _____

For patients with financial hardship or other extenuating circumstances a payment plan can be worked out with the office.