Dermatology Consultants

2424 Harrodsburg Road, Suite 200
Lexington, Kentucky 40503

PATIENT REGISTRATION FORM

Last Name:	First Name:	M.I.
SSN:	Date of Birth:	Sex: Male ❒ Female ❒
Marital Status: Single Married Divorced Widowed Significant Other	Race:	
Mailing Address:		
City:	State:	Zip:
Employer:	Occupation:	

Home Phone __________ -___________ -_____________ Cell Phone__________ -___________ -___________

Work Phone __________ -___________ -_____________ Email ______________________________________

How did you hear about us?

Primary Care/Referring Physician:

Emergency Contact:
Name: ____________________________________ Relationship: _____________________________________

Phone: __________- __________- __________

PAYMENT INFORMATION: We accept cash, checks, Mastercard, Visa, American Express, and Discover. Payment is due at time of service for non-insured patients. Please provide your insurance cards for our office to copy. **All insurance co-payments are due at time of service.**

If you have more than one insurance, you are responsible to identify the order your insurance is to be billed.

Primary Insurance Name:

Secondary Insurance Name:

Important Authorization:

I hereby authorize the release of my medical record or any information contained in this record to **primary care** and/or **referring physicians**.
I also authorize Dermatology Consultants, P.S.C., to release any information necessary to secure payment on my behalf or on the behalf of my dependents. I authorize payment directly to Dermatology Consultants, P.S.C., for medical treatment on any and all medical services rendered. I further understand that I am responsible for all fees not paid by my insurance and the balance is due within 30 days receipt of a patient statement. This authorization remains valid unless revoked in writing.

Signed: ____ **Date:** ______________________________

Designation of Personal Representative

Dermatology Consultants

2424 Harrodsburg Road, Suite 200, Lexington, KY 40503 – (859) 278-9492

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the name(s) of the person(s) as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office. Please choose *ONE* of the following options.

☐ **Patient Declines Personal Representative**

OR

Designation Section

I, _____________________________________ (print name) hereby nominate the following person (s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Print Name of Personal Representative #1____

Print Name of Personal Representative #2____ _

The person(s) is to be afforded all of the privileges that would be afforded to me with respect to my health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Privacy Officer, Dermatology Consultants, P.S.C., 2424 Harrodsburg Road, Suite 200, Lexington, KY 40503. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

____ ________________________________
Signature Date

Revocation Section

I hereby revoke this designation of a personal representative.

____ ________________________________
Signature Date

Dermatology Consultants

DERMATOLOGY CONSULTANTS
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

As a patient of Dermatology Consultants, I hereby acknowledge receipt of

Dermatology Consultants' Notice of Privacy Practices

Name [print please]: ____

Signature: ____

Date: ____

OR

I am a parent or legal guardian of _____________________________________ [patient name]. I hereby acknowledge receipt of Dermatology Consultants' Notice of Privacy Practices with respect to the patient.

Name [patient print]: ____

Relationship to Patient ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ____

For office use only:

____ Patient refused or unable to sign

Comments:
____
____