LASER + SKIN INSTITUTE
PATIENT REGISTRATION, PRIVACY, & CONSENT

PATIENT INFORMATION (please print clearly with full detail)

Patient's Last Name _____Patient's First Name _____M.I. _____
Date of Birth _____ Sex ___M ___F Social Security # _____
Street Address / Apt # _____City & State _____ Zip _____
If the guarantor, how would you like to be addressed? _____ Email _____
Home Phone # ( )_____ ___Child ___Single ___Married ___Widowed ___Separated ___ Divorced
Business Phone # ( )_____Patient's Employer _____
Cell Phone # ( )_____ Referring Physician and location _____
Emergency Contact (Name and Phone #) _____

RESPONSIBLE PARTY INFORMATION (if different from patient)

Last Name _____ First Name_____ M.I. _____
Date of Birth _____ Sex ____ M _____ F Social Security # _____
Street Address _____ City, State _____ Zip _____
Home Phone # ( )_____ ___Child ___Single ___Married ___Widowed ___Separated ___ Divorced
Business Phone # ( )_____Relation to Patient _____
Cell Phone # ( )_____

PRIVACY INFORMATION

Employees of this office must have your permission to relay your medical information on the phone. Please let us know how you would like to be contacted. If you do not give us specific permission to speak to your family members we will assume that you do not want any information relayed to anyone in your household. Please *circle* which ways we may communicate with you.

Home Phone **Cell Phone** **Work Phone**

Please specify the names of people who you authorize this office to discuss your medical care and test results with:
_____
_____
May we leave benign pathology reports or normal laboratory results on your home answering machine? Yes or No
May we leave benign pathology reports or normal laboratory results on your cell phone voice mail? Yes or No

_____ Patient / Guarantor initials to acknowledge

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 Bill of 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. 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.

The patient / guarantor understands:
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 Policies
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

_____ Patient / Guarantor initials to acknowledge

ASSIGNMENT AND RELEASE

Your initials and signature acknowledges your understanding of the Privacy and Patient Consent sections on this form. Your signature also authorizes the Laser and Skin Institute to release 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. "I authorize any benefits due be paid directly to my physician. I also understand payment is expected at the time of service (all co pays and balances must be paid when the service is given)."

_____ _____
Patient Signature Parent Signature (if patient is a minor)
Date _____