Demographics and Consent Form

Name: _____ **Age:** _____ **DOB:** _____ **Gender:** ☐ Male ☐ Female ☐ Other

Address: _____**City:**_____**State:**_____**Zip**_____

Home (_____) _____ **Work** (_____) _____ **Cell Phone** (_____) _____

SSN: _____ **Email:** _____ **Preferred Language:** _____

Race: ☐Caucasian ☐African American ☐Native Hawaiian ☐Alaska Native ☐Asian ☐American Indian ☐Other_____

Ethnicity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino ☐ Unreported/Refuse to report

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Partner ☐ Refuse to report

Advance Directive: Do you have a Living will: ☐ Yes ☐ No Do you have a Do Not Resuscitate Order: ☐ Yes ☐ No

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Emergency Contact: _____ **Relationship:** _____

Home#_____ **Work#**_____ **Cell#**_____

Primary Care Doctor Name: _____**Phone:** _____ **Fax**: _____

Referred by Doctor Name: _____**Phone:** _____ **Fax**: _____

☐ **Self-Referral**

Employer Name: _____ **Phone:** _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retire ☐ Active Military Duty ☐ Unknown

Student Status: ☐ Full Time Student ☐ Part Time Student ☐ Not a Student

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Payment Agreement

Medicare Patients:
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me at the Pennsylvania Centre for Dermatology, LLC including physician services. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related service.

All Patients:

PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, Visa or Master Card. **I understand that there will be a fifty dollar ($50) fee for appointments not kept and appointments cancelled with less than twenty four hours' notice.** I also understand that there will be a thirty five dollar fee for all returned checks. Your signature below indicates that you accept these policies. Further, your signature authorizes the Doctor to release such 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.

Patient Signature or Legal Guardian: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of **Pennsylvania Centre for Dermatology, LLC**'s Notice of Privacy Policies (effective date September 23, 2013) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

_____

_____

Signed: _____ **Date**: _____

Consent for Communication of Information

In addition to the information that is released as outlined in the Notice of Privacy Policies (above), please indicate any additional individuals with whom we may communicate regarding your protected health information:

☐ Name: _____ Relationship: _____ Tel#_____

☐ Name: _____ Relationship: _____ Tel#_____

☐ Name: _____ Relationship: _____ Tel#_____

For the purposes of communicating test results, prescription refill requests, and other protected health information, I authorize my physician and/ or his/her designee to utilize the following mechanism/s:

☐ On my home answering machine

☐ On my cell phone message system *PLEASE VERIFY CONTACT NUMBERS ON PREVIOUS PAGE*

☐ On my office voice mail

Email is NOT a secure mechanism to communicate protected health information. We prefer to NOT communicate via this mechanism. However, we understand that when the other options listed above are not available, you may request communication via this mechanism. By listing your preferred email address below, you authorize our office to communicate with you via this email address. You also accept any and all risk that may result from a security breach and potential release of information contained in these email communications.

☐ Preferred email address: _____

I have the right to revoke and change my consent options as listed above. When circumstances change regarding my response, I will submit written changes, revocation, limitations, and restrictions to the Pennsylvania Centre for Dermatology, LLC, at the current address. Your physician and the Pennsylvania Centre for Dermatology, LLC, will not be held liable for communication of protected health information via the consented option(s) above without an updated written consent form.

Signed: _____ **Date:** _____
