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DERMATOLOGY OF EASTERN IDAHO

703 Rigby Lake Drive
Rigby, Idaho 83442
FAX: (208) 745-0212

PATIENT INFORMATION SHEET

Patient: Name ___________________________________ Today's Date ________________

Gender: Male Female Marital Status____________ Date of Birth_____________ Age_______

Mailing Address__________________________ City___________ State________ Zip____________

Physical Address (if different than mailing address)____

E-mail address____

Cell Phone Number ______________________ Home Phone Number __________________________

Work Phone______________________ Place of Employment______________________________

Social Security Number______________________ Patient was referred by:______________________

Preferred Language____________________________ Race/Ethnic Group________________________

Preferred Method of Contacting You____

Spouse's Name__________________________ Spouse's Date of Birth__________________________

Spouse's Phone _______________________ Spouse's Employment ___________________________

Spouse's Social Security Number _________________ Spouse's Email _________________________

***Person Responsible for Payment*:** Name________________________ Date of Birth_______________

Mailing Address__________________________ City___________ State________ Zip____________

Physical Address (if different than mailing address)____

Cell Phone Number________________________ Home Phone Number _________________________

Social Security Number___________________________ Relationship to Patient__________________

Place of Employment__________________________________ Work Phone Number _____________

Address____________________________ City______________ State___________ Zip___________

Emergency Contact (***<u>Please list someone Not living with you</u>***): Name________________________________

Home/Cell Phone______________ Work Phone ______________*Relationship*_______________________

Address____________________________ City______________ State____________ Zip___________

Insurance Information

(Copies of Insurance Cards and Photo ID will be taped here)

Insurance Company___________________________________ I.D. Number______________________

Group Number____________________ Address____

Name of Insurance Policy Holder_____________________________ Date of Birth__________________

Social Security Number________________________________

Secondary Insurance Company__________________________ I.D. Number______________________

Group Number____________________ Address____

Name of Insurance Policy Holder____________________________ Date of Birth_________________

Social Security Number________________________________

***Information Release*:**

I hereby authorize Dermatology of Eastern Idaho to release any information acquired in the course of my examination or treatment to the insurance carriers. I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to Dermatology of Eastern Idaho.

***Assignment of Insurance Benefits*:**

I assign my insurance proceeds and/or health benefits to Dermatology of Eastern Idaho and authorize my insurance company to pay these assigned proceeds directly to Dermatology of Eastern Idaho. I understand that Dermatology of Eastern Idaho will submit billings to my insurance company but only as a courtesy for me. I understand that I am financially responsible for the charges not covered by my insurance company.

I give my informed consent for physicians, and medically licensed staff members of Dermatology of Eastern Idaho to perform necessary treatment for me or for my minor child.

Signature____ ___________________________

(relationship to patient)

Medigap Patient's Assignment Authorization

I request that payment of authorized Medigap benefits be made on my behalf to Dermatology of Eastern Idaho, for any services furnished to me by Dermatology of Eastern Idaho. This authorization applies to all occasions of services until it is revoked.

Patient's Signature____Date________________________

HIPAA 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 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.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthy care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthy 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 of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices, should it become necessary within the law.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I am a patient of Dermatology of Eastern Idaho. I hereby acknowledge receipt of Dermatology of Eastern Idaho's Notice of Privacy Practices.

Signature: ___________________________________

Date: _______________________________________

Do we have permission to leave a message at your preferred method of contact? ☐Yes ☐ No

I am a parent or legal guardian of

__________________________________(patient name).

I hereby acknowledge receipt of Dermatology of Eastern Idaho's Notice of Privacy Practices with respect to the patient.

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ___________________________________

Date: _______________________________________