Alexandria ASSOCIATES IN DERMATOLOGY

PATIENT AUTHORIZATION & CONSENT FOR TREATMENT

PLEASE PROVIDE THE REQUESTED INFORMATION BELOW IN ORDER TO MANAGE YOUR CARE, INSURANCE, CONSENTS, AND METHODS FOR CONTACT

PATIENT DEMOGRAPHICS:

NAME (FIRST, MIDDLE, LAST):_____

DATE OF BIRTH (MONTH, DATE, YEAR): _____

SOCIAL SECURITY NUMBER:_____

GENDER: _____RACE:_____ETHNICITY:_____

MARITAL STATUS:_____

STREET ADDRESS:_____ UNIT/APARTMENT #: _____

CITY: _____ STATE:_____ ZIP: _____

PHONE (H): _____(C): _____ (W): _____

EMAIL ADDRESS: _____

PREFERRED CONTACT METHOD (CHECK ONE): ❑ HOME ❑ CELL ❑ WORK ❑ TEXT ❑ EMAIL

❑ OK TO LEAVE A VOICEMAIL MESSAGE IF WE CANNOT REACH YOU? (IF YES, CHECK)

❑ OK TO PROVIDE APPOINTMENT REMINDERS? (IF YES, CHECK)

PRIMARY CARE PHYSICIAN (PCP) INFO:

PCP NAME:_____ PCP PHONE#:_____

PCP ADDRESS: _____

REFERRING PROVIDER INFO:

NAME:_____ PCP PHONE #:_____

ADDRESS: _____

INSURANCE INFO:

PRIMARY INSURANCE NAME:_____ MEMBER ID#:_____

POLICY HOLDER NAME: _____DOB:_____

ADDRESS FOR THE **PRIMARY INSURANCE** (STREET, CITY, STATE):

_____

DO YOU HAVE **ANOTHER HEALTH INSURANCE POLICY?** (i.e. *SECONDARY INSURANCE*) ☐**YES** ☐**NO**

SECONDARY INSURANCE NAME:_____ MEMBER ID#:_____

POLICY HOLDER NAME: _____DOB:_____

ADDRESS FOR THE SECONDARY INSURANCE (STREET, CITY, STATE):

_____

RESPONSIBLE PARTY INFO (WHO'S ULTIMATELY RESPONSIBLE FOR YOUR BILL?):

❑ CHECK HERE IF SAME AS PATIENT INFO ABOVE

NAME: _____ RELATIONSHIP: _____

ADDRESS (STREET, CITY, STATE): _____

PHONE (H):_____ (C):_____ (W):_____

PREFERRED CONTACT METHOD (CHECK ONE): ❑ HOME ❑ CELL ❑ WORK ❑ TEXT ❑ EMAIL

EMERGENCY CONTACT INFO (WHO CAN WE CONTACT IN CASE OF AN EMERGENCY?):

NAME: _____ RELATIONSHIP: _____

ADDRESS (STREET, CITY, STATE ZIP): _____

PHONE (H):_____ (C):_____ (W):_____

GENERAL CONSENT (THIS PROVIDES US WITH YOUR CONSENT TO RECEIVE CARE & TESTING):

____ **(INITIAL HERE)** General Consent: I consent to medical care at Alexandria Associates in Dermatology. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made.

____ **(INITIAL HERE)** Consent for electronic prescription submission

BY SIGNING THIS FORM, I UNDERSTAND THAT I CONSENT AND AUTHORIZE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT THE FOLLOWING :

a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; i.e. release of radiographs and or treatment plans to referring physicians)

b) Obtaining payment from third party payers (i.e. my insurance company)

c) The day-to-day healthcare operations of our practice.

WHO ARE YOU AUTHORIZING ACCESS OF INFORMATION TO & WHAT INFO MAY BE RELEASED?

May we discuss your medical condition with any member of your family or medical team? YES NO

If YES, please provide the name & contact information for the person(s) with whom we may discuss your care:

NAME:_____

RELATIONSHIP:_____

PHONE: _____ EMAIL ADDRESS:_____

WHAT INFORMATION MAY BE SHARED? (CHECK ALL THAT APPLY):

- ❑ FINANCIAL INFORMATION
- ❑ LABS/PATHOLOGY RESULTS
- ❑ BREACH OF INFORMATION
- ❑ MEDICAL OFFICE VISIT NOTE

SIGN BELOW TO ACKNOWLEDGE AGREEMENT WITH THE ABOVE GENERAL CONSENT & THAT YOU WERE PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES:

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____