PATIENT REGISTRATION

|  |
| --- |
| Date For Internal Use Only Patient Number |
| **PATIENT INFORMATION** |
| Social Security # Date of Birth |
| First Name Middle Last Name |
| Home Address City State Zip |
| Email Address Race \_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender (Circle as many as are appropriate)  Birth Sex: Male Female Transgender Other  Current Sex: Male Female Transgender Other |
| Marital Status Married Single Home Phone ( )  (Circle One) Divorced Widowed Cell Phone ( ) |
| (Circle One) Employed Retired Disabled Work Phone ( )  F/T Student Other |
| Employer Referring Physician |
| How did you hear of us? |
| PRIMARY INSURANCE INFORMATION |
| **PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST** |
| Insurance ID # GR # |
| Name of Insured DOB SS# |
| SECONDARY INSURANCE INFORMATION |
| I Insurance ID# GR # |
| Name of the Insured DOB SS# |
| EMERGENCY CONTACT |
| Relationship |
| First Name Middle Last |
| Home Phone ( ) Work Phone ( ) Cell ( ) |
| SPOUSE/GUARANTOR/RESPONSIBLE PARTY |
| Social Security # Sex Date of Birth |
| Relationship Daytime Phone ( ) |
| First Name Middle Last Name |
| Address City State Zip |
| Employer Address |
| City State Zip |

**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired during my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.**

|  |
| --- |
| **SIGNATURE** (Patient or Parent if Minor) DATE |

Patient Privacy Questionnaire and Notification

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

**Contact Information**:

I would prefer to be contacted at\*: \_\_\_\_\_\_\_Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Other #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_May ONLY leave information with me. (If you check here, no other choice should be marked).

\_\_\_\_\_\_May leave appointment reminders on my answering machine/voicemail.

\_\_\_\_\_\_May leave lab results on my answering machine/voicemail.

\_\_\_\_\_\_May leave general questions/information on my answering machine/voicemail.

\_\_\_\_\_\_May leave a message with a call back number only.

**Please list the name of the individual and relationship of anyone we may give information to**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_May leave appointment reminders with the above listed person

\_\_\_\_\_\_May leave lab results with the above listed person

\_\_\_\_\_\_May leave general questions/information with the above listed person

\_\_\_\_\_\_May discuss billing information with the above listed person

\_\_\_\_\_\_I prefer that all healthcare messages be given to the above listed person

\*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

**By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney’s fee allowed by Tennessee Law.**

Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**University Dermatology**

**1928 Alcoa Highway, Building B, Suite 214**

**Knoxville, TN 37920**

**865-305-8400**

**Authorization and Release for Use of Medical Records, Images and Photographs**

**Please check only one, sign, and date**

In accordance with state and federal regulations, including Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), **I hereby grant permission for the use** of any of my medical records including illustrations, photographs and other imaging records created in my case or surgery for teaching or research purposes, including but not limited to presentations at scientific meetings, publication in medical journals, textbooks or other media provided my name is not used in connection therewith.

Patient Signature Date

Printed Patient Name

Medical Record Number

Witness Signature

In accordance with state and federal regulations, including Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I consent to my pictures being taken prior to, during, or after surgery. **I do not wish these pictures would be used** for purposes of teaching or research purposes, including but not limited to presentations at scientific meetings, publication in medical journals, textbooks, or other media.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Minors:** I have read the above authorization and release. I am the parent, guardian or conservator of , a minor. I am authorized to sign this consent on his/her behalf, and I grant this consent for the purposes described above.

Parent/Guardian Signature Date

Printed Patient Name

Medical Record Number

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**(865) 305-8400**

**INSURANCE PAYMENT POLICY**

Thank you for choosing University Dermatology. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.
2. **Co-Payments.** All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.
3. **Non-covered Services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit with your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim.
5. **Claim Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any moneys owed after we have received payment from Medicare and/or a secondary policy that you might have.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.
7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Partial payments will not be accepted, unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

**Signature of Patient or Responsible Party Date**

**University Dermatology**

**1928** **Alcoa Highway, Building B, Suite 214**

**Knoxville, TN 37920**

**(865) 305-8400 fax (865) 305-8573**

**INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize **UNIVERSITY DERMATOLOGY** to obtain the medical records of:

Name: Date of Birth:

Telephone Number: SSN:

Address:

The request and authorization apply to:

* Complete Medical Records □ Pathology Reports
* Discharge Summary □ Laboratory Tests
* History & Physical Exam □ Consultation Reports
* Orders and Progress Notes □ Operative Reports
* Radiology Reports □ Other:

Records to be released from:

Name:

Address:

For the following purpose: **MEDICAL TREATMENT**

The authorization will expire one year from date of signature.

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Responsible Party Date