Medical Information Release Form
(HIPAA Release Form)

Patient Name: ______________________________
Patient ID Number: _________________________
Date of Birth: ______________________________

Release of Information

(___) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

(____) Name of Spouse ____________________________________

(____) Names of Child(ren) ________________________________

(____) Name of Other _____________________________________

(____) Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Updated March 19, 2014

REGISTRATION FORM

Section 1: **Patient Information**
Date________________

Name: ____ I prefer to be called: ______________________

Address: ____________________________________City:____________State:________Zip____________

Phone (____) ______________ Work Phone (____) ______________ Cell Phone (_____) _________________

Date of Birth: _____________ Social Security ___________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_________________________ City/State________________________ ☐ FT ☐ PT

Employer ____

Spouse or Parent's Name: _________________________ Spouse/Parent's Employer_______________________ Spouse's/Parent's Work Phone__________

Whom may we thank for referring you? ____

Person to contact in case of emergency_______________________________ Phone______________________

Email Address___________________________________

Height: _________ Weight: __________ Race: __________ Ethnicity: __________ Language: ___________

Updated March 19, 2014

Section 2: **Past Patient Medical History**

Circle All that Apply	Details
None	______________________________
Asthma/Breathing Problems	______________________________
Bleeding Disorder	______________________________
Cancer	______________________________
Diabetes	______________________________
Heart Disease	______________________________
Hepatitis	______________________________
High Blood Pressure	______________________________
Infectious Disease (HIV)	______________________________
Skin Cancer	______________________________
Syncope/Fainting	______________________________
Thyroid Disorder	______________________________
Tuberculosis	______________________________

Section 3: **Past Patient Surgeries**

Surgeries	Date	Anesthesia Complications	Notes
1.			
2.			
3.			
4.			
5.			
6.			

Section 4: **Patient Family History**

Circle All That Apply **Afflicted Family Member**

Adopted Unknown

No Family History of Problem ______________________

Abnormal bleeding/clotting ______________________

Anesthesia Problems ______________________

Autoimmune Disorders ______________________

Cancer ______________________

Diabetes ______________________

Drug Allergies ______________________

Endocrine Disease ______________________

Heart Disease ______________________

High Blood Pressure ______________________

Kidney Disease ______________________

Liver Disease ______________________

Skin Cancer ______________________

Skin Disease ______________________

Section 5: Drug Allergies

	Allergy	Reaction	Notes
1.			
2.			
3.			
4.			
5.			
6.			

Section 6: Medications

	Drug	Dosage	Prescribed By	Bad Reaction?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Section 7: **Patient Social History**

Yes **No**

Alcohol
Illicit Drugs
STD (Sexually Transmitted Disease)
High Risk Factors (Health)
Tobacco Use

Section 8: **Patient Ability to Heal**

Yes **No**

Is your skin fragile or burn easily?

Do you form thick or raised scar from a cut?

Do you wax or use depilatories on your face?

Do you ever get cold sores?

Section 9: **Female Questions**

Yes **No** **N/A**

Do you have regular periods?

Are you going through menopause?

Are you pregnant or lactating?

During pregnancy, did you get hyper
Pigmentation or masking?

Bopp Dermatology and Facial Plastic Surgery

FINANCIAL POLICY

We believe that part of a good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to provide the best possible care for you.

1. **Payment** is expected at time of service. We accept cash, checks, visa, mastercard and discover. We do not accept american express. Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered amount from the insurance company. If you do not have insurance payment is due at time of service.
2. **Insurance** We are participating providers with many insurance companies. We will file all of your insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.
3. **Return checks** will incur a $25.00 service charge. You will be asked to bring in cash, certified check or money order to cover the amount of the check and the service fee. All bad checks written at the office are subject to collection action and will be prosecuted by Jefferson Parish District Attorney's office.
4. **Form Fees/Medical Records** require a pre-payment for the completing of these forms. Charge is determined by the number of pages that are copied.
5. **Cancellations, No-Show or Missed Appointments** if you do not cancel your appointment at least 24 hours before or if you no show, we will assess you a $50.00 charge for dermatologist appointment and $100.00 for Scheduled procedure and Injectable.

I have read and understand the practice's financial policy and I agree to the terms. This may be amended from time to time.

__________________________________ ________________

Signature Date

____

Print name

Updated March 19, 2014

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name: ___________________________________ Birthdate: _____________________

Signature: ____

Date: ____

Updated March 19, 2014

Bopp Dermatology & Facial Plastic Surgery
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medial information.

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Allow patients to request electronic copies of their patient health information
4. Follow the terms of the notice that is now in effect.

We Have The Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
3. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

HIPAA REGULATIONS / USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTHCARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

I understand that I may revoke this authorization at any time by giving written notice to our office.
I also understand that if this authorization is being signed as a condition of obtaining insurance coverage and I revoke it; the insurance company has a right to contest my claims under the policy. I understand that under most circumstances, a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

- I understand that Bopp Dermatology requires parent consent for treatment of all minors.
- I also understand that Bopp Dermatology may call via telephone and leave messages on answering machines or voice mail regarding appointments or patient information.
- I acknowledge that I have received, read and understand the Notice of Privacy Practices and Hipaa regulations.