INTEGRATED DERMATOLOGY GROUP

REGISTRATION INFORMATION

INTEGRATED DERMATOLOGY OF TIDEWATER

PATIENT INFORMATION

DATE:

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
HOME ADDRESS	CITY	STATE	ZIP	SEX	( ) MALE ( ) FEMALE
SPOUSE'S NAME	HOME #	WORK #			
EMAIL ADDRESS	MOBILE #	MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST	MI	HOME #
ADDRESS	CITY	STATE / ZIP	SOCIAL SECURITY #
EMPLOYER	OCCUPATION		WORK #
EMPLOYER'S ADDRESS	CITY	STATE / ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER
MOTHER'S NAME	MOTHER'S BIRTHDATE	FATHER'S NAME	FATHER'S BIRTHDATE

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS		☐ FULL-TIME ☐ NOT EMPLOYED ☐ SELF EMPLOYED
CITY / STATE / ZIP		☐ PART-TIME ☐ ACTIVE MILITARY ☐ RETIRED

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME #
ADDRESS	CITY / STATE / ZIP	WORK #

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER	Effective Date
ADDRESS		CITY / STATE / ZIP	PHONE
SECONDARY INSURANCE		CARDHOLDER	DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER	Effective Date
ADDRESS	CITY	STATE / ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of Tidewater LLC of any medical benefits payable to me for the services provided at Integrated Dermatology of Tidewater LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

I also understand that if I do not cancel my appointment within 24 hours of my appointment time I am subject to a $25 fee for exam visits and $50 fee for surgical or cosmetic visits.

x

Patient Signature or Signature of Guardian or Parent — Date

MEDICARE PATIENTS ONLY - Lifetime Signature on File and Lifetime Consent

I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of Tidewater LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology of Tidewater LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

x

Signature of Beneficiary — Medigap Insurer — Medigap # — Date

INTEGRATED DERMATOLOGY GROUP

Jonathan Schreiber, MD, PhD
Integrated Dermatology of Tidewater

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 health 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 health 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 Practice and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- 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.

This Consent was signed by: _____
Printed Name – Patient or Representative

X _____ __/__/__
Signature Date

Relationship to Patient
(if other than patient): _____

Witness:

_____
Printed Name – Practice Representative

X _____ __/__/__
Signature Date

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PATIENT FINANCIAL REPONSIBILTY FORM

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

To assist you in finding out what coverage you have, feel free to ask for assistance in finding phone numbers or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement it will be your responsibility to furnish this referral at the time of service. Failure to do so may require you to reschedule your appointment and/or accept full responsibility for payment. Some insurances state you cannot go out of network. Many companies have instituted a mandatory second opinion program, and these are changing day by day. We cannot keep up with the changes and are often unaware of them until it is too late.

Please call your insurance company and learn about your coverage, it may save a lot of confusion in the long run. Thank you.

This Consent was signed by: _____

Printed Name – Patient or Representative

X _____ __/__/__

Signature Date

Relationship to Patient
(if other than patient): _____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE
I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology LLC of any medical benefits payable to me for the services provided at Integrated Dermatology LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.
X
Patient Signature or Signature of Guardian or Parent Date
MEDICARE PATIENTS ONLY – Lifetime Signature on File and Lifetime Consent
I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
X
Patient Signature or Signature of Guardian or Parent Date

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DERMATOLOGY GROUP

PATIENT CONTACT PREFERENCES

The patient wishes to be contacted in the following manner:

HOME PHONE#:

- O It is okay to leave messages with detailed information
- O Please only leave messages with department/office name and call-back number
  It is okay to give information to the family members listed below:

CELL PHONE#:

- O It is okay to leave messages with detailed information
- O Please only leave messages with department/office name and call-back number
  It is okay to give information to the family members listed below:

WORK PHONE#:

- O It is okay to leave messages with detailed information
- O Please only leave messages with department/office name and call-back number
  It is okay to give information to the co-workers listed below:

E-MAIL ADDRESS:

- O It is okay to contact this patient through e-mail
- O Please only send messages with department/office name and call-back number

WRITTEN COMMUNICATION (Mailing Address):

- O It is okay to send this patient written medical information to the address listed above

It is okay to speak with the following people regarding the patient's health information, according to the preferences set above:

Contact Name: Relationship: