# WINE COUNTRY DERMATOLOGY

## BRENT LOFTIS DO, INC.

## REGISTRATION/CONSENT FORM

Today's Date:

### PATIENT INFORMATION

| Last Name: | First Name: | Middle Initial: | Mr. Mrs | Miss Ms. | Marital Status<br>Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name?<br>❑ Yes ❑ No | If not, what is your legal name? | Former Name: | Birth Date: | Age: | Sex: ❑M ❑F |
|---|---|---|---|---|---|

| Preferred Language: | Ethnic Group/Race: |
|---|---|

| Social Security Number: | Home Phone: | Cell Phone (Required): | IF WE NEED TO CONTACT YOU:<br>❑ Ok to leave detailed voicemail<br>❑ Leave call back number only |
|---|---|---|---|

| Street Address/ PO Box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: |
|---|---|

| Email Address (Required): | Consent to communicate via email □ Yes □ No |
|---|---|

**PERSON(S) WE ARE AUTHORIZED TO RELEASE MEDICAL RESULTS TO (IF ANY):**

Other family members seen here:

| Primary Care Physician: | Phone Number: |
|---|---|
| Referring Physician: | Phone Number: |
| Spouse's Name: | Phone Number: |
| Spouse's SSN: | Spouse's Birth Date: |
| Employer: | Employer's Phone Number: |

### IN CASE OF EMERGENCY

| Name of Local Friend or Relative (not living at same address): | Relationship to Patient: | Home Phone Number: | Work Phone Number: |
|---|---|---|---|

### INSURANCE INFORMATION

**Please give your Insurance Card and Photo ID to the receptionist.**

| Person Responsible for Bill: | Birth Date: | Address (if different): | Home Number: |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer Address: | Employer Phone Number: |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance:

| Subscriber Name: | Subscriber SSN: | Birth Date: | Group # | Policy # | Co-Payment $: |
|---|---|---|---|---|---|

| Patient's Relationship to Subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

| Name of Secondary Insurance (if applicable): | Subscriber Name: | Group # | Policy # |
|---|---|---|---|

| Patient's Relationship to Subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

**AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:**

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF WINE COUNTRY DERMATOLOGY ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN". I HEREBY AUTHORIZE WINE COUNTRY DERMATOLOGY TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO WINE COUNTRY DERMATOLOGY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, AND INSURANCE COMPANY.

**PATIENT INFORMATION CONSENT:**

I UNDERSTAND THAT WINE COUNTRY DERMATOLOGY MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES WINE COUNTRY DERMATOLOGY TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW WINE COUNTRY DERMATOLOGY PRIVACY NOTICE, TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, WINE COUNTRY DERMATOLOGY MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

**MEDICARE PATIENTS:** I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO WINE COUNTRY DERMATOLOGY.

**HIPPA ACKNOWLEDGEMENT:**

I HAVE RECEIVED AND HAVE READ WINE COUNTRY DERMATOLOGY'S NOTICE OF PRIVACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

☞ _____

List authorized Representative or N/A

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.**

☞ _____ _____

PATIENT OR GUARDIAN SIGNATURE DATE