

HIPAA and Policy Registration (New Patient Form)

Patient: _____ Date of Birth: _____

Last name, First Name, MI

E-mail address: _____ @ _____

This information is being requested by Associated Dermatologists, PC in order to comply with the government guidelines for "Meaningful Use" for our Electronic Medical Records. It is designed to improve health information to improve quality of healthcare.

Race:

- Asian
- American Indian/Alaskan Native
- Native Hawaiian
- White
- Other Pacific Islander
- More than 1 race
- Black/African American
- Unreported/Refused to report

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Refused to report

Preferred Language (this does not imply that this language will be spoken for your visit, but is for reporting purposed only):

- English
- Other
- Spanish
- Refused to report

Please read the following policies and procedures of Associated Dermatologists, PC:

It is your responsibility to request and bring your referral from your Primary Care Physician if one is required by your insurance plan.

If your insurance policy requires that you pay a co-pay, this will be requested at the time you check-in for your appointment.

Depending upon your insurance, you may have additional charges from an outside lab for pathology procedures.

If your insurance should change, you need to notify us of such changes in advance of your appointment, otherwise, you may be responsible for your charges.

If we are not contracted with your 2ndary insurance or if Medicare does not forward it to your 2ndary insurance, you will be responsible for submitting such claims.

This acknowledges that you have been notified of our HIPAA Patient Privacy Policy (revised September 2013) and that you were given the option to receive a paper copy, view it on our website (www.assocdermpc.com), or review the "waiting room" copy.

Patient Signature: _____ Date: _____

(Guardian's signature if patient is a minor)

PTREG2013/HIPAA Reg

For office Personnel:	Patient Account #: _____
Scanned by: _____	Date: _____

HIPAA and Policy Registration (Established Pt. form)

Patient: _____ Date of Birth: _____

Last name, First Name, MI

E-mail address: _____ @ _____

Please read the following policies and procedures of Associated Dermatologists, PC:

It is your responsibility to request and bring your referral from your Primary Care Physician if one is required by your insurance plan.

If your insurance policy requires that you pay a co-pay, this will be requested at the time you check-in for your appointment.

Depending upon your insurance, you may have additional charges from an outside lab for pathology procedures.

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Patient Signature: _____ Date: _____

(Guardian's signature if patient is a minor)

For office Personnel: Patient Account #: _____

Scanned by: _____ Date: _____