SAUL DERMATOLOGY

5002 Highway 39 N Bldg. A
Meridian, MS 39301
Phone: 601-512-0500 Fax: 601-512-0505

Patient Information

Patient: _____
First Middle Last

Mailing Address: _____
_____
City State Zip

Social Security #: _____
Date of Birth: _____/_____/_____ Age: _____

Marital Status: ___Single ___Married __Separated __ Divorced __ Widowed
Spouses Name: _____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female
Race: ☐ Caucasian ☐ African-American ☐ Asian
☐ American Indian ☐ Other _____
Ethnicity: ☐ Not Hispanic or Latin ☐ Hispanic/Latin
Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Email Address: _____
Employer Name: _____
Employer Address: _____
_____
City State Zip

Emergency Contact

In case of Emergency Contact (Name) _____ (Relationship) _____ (Phone) _____

Responsible Party Information

If patient is a minor, parent or guardian is completing registration sheet

Name: _____
Mailing Address: _____
_____
Social Security #: _____
Date of Birth: _____/_____/_____ Age: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Employer: _____
Employer Address: _____
Street City State Zip

Insurance Information **Monthly Statement preference: _____ (Text) _____(Email) _____(Paper/Mail)**

It is the patient's responsibility to notify the office of any and all insurance changes that may occur.

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Mailing Address:	Mailing Address:
Patients Relationship to Subscriber:	Patients Relationship to Subscriber:
Subscriber's Social Security #:	Subscriber's Social Security #:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's Employer:	Subscriber's Employer:
ID #:	ID #:
Group #:	Group #:

_____ _____ _____
Signature of patient or authorized person Relationship to patient Date

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Consent to Treatment

I hereby give my permission for **Saul Dermatology P.A.** to give me, my child, or the above named minor for who I accept responsibility medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.

I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- I understand and consent that certain conditions are routinely photographed at the request of the physician and may be used by him/her in the diagnosis and documentation of medical conditions and/or purpose of medical education. I further understand that my identity will be concealed and my privacy maintained if the material is used for educational purposes.

Third Party Laboratory Consent

I understand that all lab testing and pathology services utilized while in the care of Saul Dermatology will be performed by a third party laboratory. I understand that I will receive a separate bill for those services rendered and I am responsible for payment of those services. Saul Dermatology has agreed to transfer my insurance at the time of service so that rendered pathology and lab services may be filed with my insurance company on my behalf.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____	_____	_____
Signature of patient or authorized person	Relationship to patient	Date

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

The ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures are posted in the office and will be given up request.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

_____	_____	_____
Signature of patient or authorized person	Relationship to patient	Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Saul Dermatology P.A. to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations.

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory/pathology test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing health care operations, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

I understand that Saul Dermatology may release to my insurance company, managed care organization, State or Federal agencies, and third party administrators and/or Workers Compensation or its agents any information needed to process my claims and/or determine benefits payable for related services. I also understand that Saul Dermatology may utilize a fax machine to transmit any or all records pertaining to my medical care for insurance reimbursement. I understand that faxing my medical records may increase the risk of accidental disclosure. I also understand that it may be necessary for Saul Dermatology to release all or part of my medical records to any consulting entity that may be involved in my care. I understand and acknowledge that Saul Dermatology may use and disclose my records to state and federal law for the purpose described in the Notice of Privacy Practices, in some cases without the requirement of authorization. Nonetheless, I authorize Saul Dermatology to use and disclose my medical records for all necessary purposes under state and federal law regulations.

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out health care operations.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____	_____	_____
Signature of patient or authorized person	Relationship to patient	Date

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Pharmacy:_____

Name: _____ Date of Birth: _____/_____/_____ Height: _____ Weight: _____

Do you smoke? Yes No

If Yes, _____ packs per day for _____ years.

Alcoholic Beverage Use: Yes No

Number of drinks/beers per week: _____

Allergies: _____

Chief Complaint (Briefly state why you are being seen today):

_____

_____

Past Medical History – Please circle all that apply:

Allergies	COPD	Gout	Leg/Foot Ulcers
Anemia	Coronary Artery Disease	Heart Attack	Liver Disease
Anxiety	Crohn's Disease	Heart Disease	Obesity
Arthritis	Dementia/Memory loss	Heartburn/Gastric reflux	Osteoporosis
Asthma	Depression	Hepatitis	Seizures
Bipolar Disorder	Diabetes	High Cholesterol	Stomach Ulcers
Bleeding Disorder/Clots	Diverticulosis	HIV	Stroke
Cancer (type) _____	Eating Disorder	High Blood Pressure	Thyroid Disease
Cataracts	Emphysema	Kidney Disease	Tuberculosis
Congestive Heart Failure	Glaucoma	Kidney Stones	Ulcerative Colitis

Other: _____

Past Surgical History – Please list all previous surgeries and year

_____

_____

Family History – Please circle if any first degree blood relatives ever had problems with:

Arthritis	Dementia	High Blood Pressure	Obesity
Asthma	Depression	High Cholesterol	Osteoporosis
Bleeding Disorder	Diabetes	Kidney Disease	Skin Cancer (add comments)
Cancer (add comments)	Heart Disease	Melanoma	Stroke

Comments: _____

Review of Systems – Please circle if you have problems now or have had within the past year

Chest Pain	Gastrointestinal	Musculoskeletal	Skin
Ears/Nose/Mouth	Genitourinary	Neuro/Seizures	Comments: _____
Endocrine	Heart	Psychiatric	_____
Eyes	Hematologic	Respiratory	_____

Medications – Please list all medications including dosage if known

_____

_____

_____

_____ _____ _____

Signature of patient or authorized person | Relationship to patient | Date