Patient Registration and Consent Form

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: _____ Marital Status: S☐ M☐

Preferred Phone: _____ M☐ H☐ W☐ Second Phone: _____

Email: _____ Send me sale & event emails: Yes☐ No☐

Address: _____
Street City State Zip

********** PATIENT UNDER 18 YEARS OLD **********

Guarantor Name: _____ Date of Birth: _____

Relationship to patient: _____ Address same as patient's? Yes☐ No☐

If address is different: _____

****

Preferred Pharmacy Name: _____ Mail Order: Yes☐ No☐

Phone Number: _____ Fax Number: _____

Address: _____ City / State: _____ _____

Emergency Contact: Phone Number:

** Can we leave detailed test results on your preferred phone? Yes☐ No☐

** I will review the patient face sheet and verify my demographic and coverage is correct. I agree to contact My Dermatologist if this information changes.

PLEASE READ AND SIGN BELOW:

ASSSIGNMENTS OF BENEFITS: I hereby authorize the release of medical benefits payment to My Dermatologist for any services rendered to me or my dependents. Additionally, I grant permission for My Dermatologist or my insurance provider to exchange any pertinent information required to process my claim properly and accurately.

CONSENT FOR TREATMENT: By signing this form, I give my consent and authorization to My Dermatologist, its licensed physicians, physician assistant, and their authorized personnel to provide necessary medical treatment to me or my dependent. This treatment may include various services and supplies, such as diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, mental health, physical function evaluations, medication prescription and administration, devices, equipment, or other related services. Additionally, I allow medical communication and treatment through telemedicine and potential collaboration with other healthcare professionals.

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CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION: I hereby authorize My Dermatologist permission to release and obtain my medical records, inclusive of protected health and billing information, between my primary care physician and other healthcare providers involved in my treatment. Additionally, I authorize sharing this information with Medicare, payer network organizations, health plans (including accountable care organizations), and their contractors as necessary for payment and healthcare operations. Furthermore, I grant permission to share the information obtained from My Dermatologist with accountable care organizations in which my provider participates, health information exchanges, and the contractors and third-party administrators of these parties for treatment, payment, and healthcare operations.

CONSENT FOR EMR RELEASES: I hereby authorize My Dermatologist to disclose my medical information to other healthcare providers who utilize the same electronic medical record (EMR) system, provided that such disclosure is in accordance with the EMR system's requirements and my authorization.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits for services rendered by My Dermatologist's physician, clinic, or supervisor be paid directly to My Dermatologist. Additionally, I hereby give authorization for releasing any medical or hospital information about me to the Center for Medicare and Medicaid Services and its agents to determine any benefits or related services payable. Furthermore, I grant permission for a copy of this authorization to replace the original document.

MEDIGAP: I request that authorized MEDIGAP benefits be made on my behalf for services rendered to me. I authorize any holder of medical information to release any information required to the applicable MEDIGAP carrier to determine these benefits payable for related services.

I hereby provide my consent to use a copy of the authorization in place of the original. Furthermore, I acknowledge that the permissions and consents granted above shall remain valid for ten years from today's date unless terminated before the expiration date through written notification to:

My Dermatologist
Attention: Business Office
5565 Blaine Avenue E, Suite 200
Inver Grove Heights, MN 55076

I understand my revocation will not apply to information already used or released in reliance on this consent. I also understand that by refusing to sign this consent or revoking this consent, this organization may not be able to provide services to me. By Signing below, I acknowledge and consent to the contents of this form.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient:_____