PRESIDIO DERMATOLOGY

Patient Name: _____ Preferred Name: _____ Age: _____

If Child, Name of Parent / Guardian: _____

Referred by: _____

**** Preferred Pharmacy / Location: _____**

Reason for today's visit: _____

_____

History of skin cancer: **yes / no**
(if yes, what type, location on body, when):

Family history of skin cancer: **yes / no**
(if yes, what type and what relationship to you):

Tanning bed history: **yes / no** **past / present**

Smoking tobacco history: **yes / no** **past / present**

Chewing / snuff tobacco history: **yes / no** **past / present**

Influenza Vaccine: **yes / no** **Date of last influenza vaccine: _____**

Medications:_____ Drug Allergies: _____

Are you experiencing:

Fever / chills		**yes / no**
Frequent infections or weakened immune system		**yes / no**
Hay fever / seasonal allergies		**yes / no**
Asthma		**yes / no**
Irregular menstrual cycle		**yes / no**
Are you:	**Pregnant**	**yes / no**
	Nursing	**yes / no**
	Trying to conceive	**yes / no**

Occupation:_____

PRESIDIO DERMATOLOGY

REGISTRATION FORM

FIRST MIDDLE LAST

Patient Name: _____

Mailing address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Appointment reminder preference: ◯ **text/SMS** ◯ **Phone Call**

OPTIONAL

Birthday : _____ **Gender:**_____ **SS#:** _____

Email address: _____

Emergency contact: _____

Primary Care Doctor: _____ **Employer:** _____

Insurance Carrier: _____

Is the Guarantor yourself (person held responsible for the bill): ◯ **Yes** ◯ **No**

Subscribers employer if not yourself: _____ **Subscribers birthday:** _____

Do you have secondary insurance: ◯ **Yes** ◯ **No**

If no, then skip the following section.

Insurance Carrier of Secondary: _____ **Employer of Secondary:** _____

Presidio Dermatology Consent to Treatment, Medical Records Release and Insurance Appeals

I request and consent treatment for myself or my child at Presidio Dermatology. I authorize the release of any medical records or other information necessary for the processing of medical claims on behalf of myself or my child.

Cancellation Policy: Our office has a 24-hour cancellation policy. Patients will be charged a $75 fee for no-shows.

Pathology Billing Notice: Pathology specimens from biopsies will be sent to UCSF or American Specialty Laboratory. You will receive a separate bill. If you have any questions or concerns about pathology prices, contact your insurance carrier directly.

Preventive Care Some insurance companies offer a fully paid preventive care visit. A comprehensive system exam is required which we do not do; therefore, we cannot bill preventative care visits. We will bill you for insurance for an office visit, but you may owe a deductible, copay, or other.

Financial Policy I understand that I am responsible for any health insurance deductibles, co-pays, and coinsurance as well as any non-covered services. Any procedure performed in the office will incur additional charges. Should Presidio Dermatology not participate with my insurance, payment is due and payable at the time services are rendered. Verification of your insurance is a courtesy and does not guarantee coverage or that we are in network with your insurance. It is your responsibility to contact your insurance company to verify. Our Tax ID is 47-5502470.

Credit Card on File In an effort to streamline and improve our billing process, we require that all of our medical patients have a credit card on file with us. Your credit card information is stored securely offsite in a PCI compliant gateway maintained by our credit card processing company. Your credit card will only be charged for past due balances after two bills have been sent, or if you request us to charge your card on file. By signing this, you authorize us to charge your credit card as described above.

HIPAA Rights and Responsibilities

You have the right to get a copy of your paper or electronic medical record, correct your paper or electronic medical record, request confidential communication, ask us to limit the information we share, get a list of those with whom we've shared your information, get a copy of this privacy notice, choose someone to act for you, file a complaint if you believe your privacy rights have been violated

We may use and share your information as we treat you, run our organization, bill for your services, comply with the law, respond to lawsuits/legal actions.

You can request, in writing, an electronic or paper copy of your medical record and health information, a correction to our health information and medical records, to contact you in a specific way (for example a different address), not to use or share certain health information for treatment, payment, or our operations,

You can ask us in writing not to share information with your health insurer for payment or our operations if you pay for a service or health care out-of-pocket in full.

You can ask, in writing, for a list of those we've shared your health information, times, and the reason.

You can file a complaint for violations with the U.S. Department of Health and Human Services Office for Civil Rights, 1 877-696-6775 or **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you. You can tell us your choices about what we share for certain health information.

We can use or share your health information with other professionals who are treating you, to run our practice, improve your care and contact you when necessary, to bill and get payment from health plans or other entities.
We can share your health information in situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a threat to anyone's health or safety.
We will share information about you if state or federal laws, court or administrative order, or subpoena require it.
We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may compromise the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We can change the terms of this notice, and which will be available upon request.

I have read and understand all the information on this page including Office Billing Policy and HIPAA Rights and Responsibilities.

Patient or Responsible Party _____ **Date** _____