



ALBANY DERMATOLOGY CLINIC

INSURANCE INFORMATION

Date: _____

PRIMARY INSURANCE (Please give card to receptionist to copy): _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: ____/____/____

ID #: _____ Group #: _____ Group Name: _____

SECONDARY INSURANCE (Please give card to receptionist to copy): _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: ____/____/____

ID #: _____ Group #: _____ Group Name: _____

Is this visit a result of a work injury? No Yes (Date Injured): _____ Did you report injury? No Yes

Description of accident: _____

Name of contact at your employment: _____ Phone #: _____

*** COPAYMENTS ARE EXPECTED AT THE TIME OF YOUR VISIT. ***

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Albany Dermatology Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Albany Dermatology Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Albany Dermatology Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Albany Dermatology Clinic Privacy Officer at 2709 Meredyth Drive, Suite 340, Albany, GA 31707.

With my consent, the Albany Dermatology Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the Albany Dermatology Clinic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential".

With my consent, the Albany Dermatology Clinic may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Albany Dermatology Clinic restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Albany Dermatology Clinic's use and disclosure of my PHI to carry out TPO.

Do you give our office permission to discuss your medical record with anyone? No Yes

If "Yes", Name and Relationship: _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the Albany Dermatology Clinic may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian