OAKVIEW
DERMATOLOGY

Patient Information

Name *(last, first middle):* _____ Birthday: _____ SSN: _____ Sex: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____ Language: _____

Text: ☐ **YES** or **NO** ☐ Voicemail: ☐ **YES** or **NO** ☐ Email: ☐ **YES** or **NO** ☐ Smoker: ☐ **YES** or **NO** ☐ | Veteran: ☐ **YES** or **NO** ☐

Email Address: _____ Primary Care Doctor: _____

Ethnicity *(select all that apply)*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Other: _____

Race *(select all that apply)*: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other ☐ Pacific Islander ☐ American Indian/Alaska Native ☐ Other:

Receipt of Notice of Financial & Privacy Practices

I am a **PATIENT/PARENT OR LEGAL GUARDIAN** *(please circle one)* of Oakview Dermatology. I hereby acknowledge receipt of Oakview Dermatology's Notice of Financial & Privacy Practices.

Patient's initials: _____ **--OR--** Parent or legal guardian initial: _____

Receipt of HIPAA Guideline

Oakview Dermatology adheres to the following HIPAA guidelines set forth by the United States Department of Health and Human Services and the Office for Civil Rights:

Patient Consent:

The patient listed above or the legal representative for the patient listed above understands:

- Reminders of upcoming scheduled appointment may be left on an answering machine or with a family member.
- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or health care operations
- Oakview Dermatology has a "Notice of Privacy Practice" that can be reviewed by the patient at any time.
- Notification regarding the availability of pathology or laboratory results may be left on an answering machine or with a family member BUT that actual result WILL NEVER be left to anyone other than the patient or family member(s) listed below.
- All of the policies listed on the Notice of Financial and Privacy Practice form will adhere to them when applicable.

Authorization for Disclosure of Medical Records: I authorize the disclosure of any of my medical records to the following individual(s)

1. _____ Name _____ Relationship _____ Phone

2. _____ Name _____ Relationship _____ Phone

_____ _____

Signature of patient or responsible party Date

Minors and POA

Is this patient under the age of 18? **YES** or **NO** || Does this patient have a POA? **YES** or **NO** || If yes to either of these please fill out the section below.

Any services not covered by the patient's insurance will become the signee's responsibility for full payment of services rendered by Oakview Dermatology, LLC.

Name of Responsible Party: _____ Birthday: _____ SSN: _____

Address: _____ Relationship: _____