FLATIRONS DERMATOLOGY PLLC

FLATIRONS DERMATOLOGY ANNUAL PAPERWORK
(To be completed yearly by **ALL** patients)

PATIENT INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____

Sex/Gender:_____ DOB:_____ Age: _____

Mailing Address:_____

Apartment or Unit #: _____ City: _____ State: _____ Zip:_____

Phone:_____Email:_____

Social Security #: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

(IF PATIENT IS UNDER THE AGE OF 18) Name of Parent or Legal Guardian: _____
DOB of Parent or Legal Guardian: _____ Is the billing address the same as the patient? [ ] Yes [ ] No

Emergency Contact

Name:_____

Phone: _____

Relationship to Patient: _____

Power of Attorney **(if applicable, please indicate who has POA)**

Name:_____

Phone: _____

Relationship to Patient: _____

NAME OF YOUR PRIMARY CARE PHYSICIAN _____

PRIMARY CARE PHYSICIAN PHONE NUMBER _____

PHARMACY NAME, PHONE NUMBER, & CITY _____

If you have completed this information in the patient portal, please inform one of our Front Office Team Members.

FLATIRONS DERMATOLOGY

CONSENT FOR CLINICAL DIAGNOSIS AND TREATMENT

I, _____, do hereby give consent to the clinical staff of **Flatirons Dermatology** to examine, treat, and counsel me. I understand there are certain hazards and risks connected with all forms of treatment and my consent is given with this knowledge

INITIAL: _____

Please list the preferred phone number(s) to call you regarding any financial, insurance, or medical information: _____ May we leave a voice message? **[ ] YES [ ] NO**
Are there any family member(s) we can speak to regarding your medical information? **[ ] YES [ ] NO**
If **YES**, please give name(s) and relationship to the patient: _____

HEALTH INFORMATION CONSENT AND PATIENT PORTAL

My Authorization (PLEASE CHECK ONE)

[ ] You may disclose non-urgent and benign medical results to me via the secure online medical records portal.

[ ] You may **NOT** disclose non-urgent and benign medical results to me via the secure online medical records portal.

I may revoke this authorization in writing. If I revoke this authorization, it does not affect any actions taken by **Flatirons Dermatology** based upon this authorization.

INITIAL: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, have reviewed a copy of **Flatirons Dermatology** Notice of Privacy Practice Information Form. I also acknowledge that if I would like a copy of the Notice of Privacy Practice Information Form that I will request one from Flatirons Dermatology Front Desk Team.

INITIAL: _____

PATIENT FINANCIAL RESPONSIBILITES

I, _____, have reviewed **Flatirons Dermatology Patient Financial Responsibilities** Policy and agree to all terms. I also acknowledge that if I would like a copy of the Patient Financial Responsibilities that I will request one from Flatirons Dermatology Front Desk Team. I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to the provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize Flatirons Dermatology and its employees, agents, and assignees to contact me via e-mail and text messaging, and to my cellular devices.

INITIAL: _____
Patient Signature: _____ **Date:** _____