MINDFUL
DERMATOLOGY

PATIENT INFORMATION

NAME (Last, First Middle Initial)	SSN #	BIRTHDATE	LANGUAGE	SEX

ADDRESS	ZIP CODE	CITY, STATE

HOME PHONE	MOBILE PHONE	WORK PHONE	RACE

MARITAL STATUS	EMAIL ADDRESS

REFERRED BY (PHYSICIAN, WEBSITE, INSURANCE, PRINT AD, PATIENT, EMPLOYER, OTHER)

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY INSURED DATE OF BIRTH	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT $
CITY, STATE ZIP / PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#
NAME OF INSURED / SSN# / BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT $
CITY, STATE ZIP / PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

MINDFUL
DERMATOLOGY

ACKNOWLEDGEMENT OF THE RECEIPT OF MINDFUL DERMATOLOGY, PLLC, OFFICE POLICIES

Patient Name:	**Account #**

Patient Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check one):**

☐ Home Phone
☐ Work Phone
☐ Mobile Phone
☐ Guardian
☐ Mailed Letter

If the above method of communication is by phone, please check the appropriate box below **(check one):**

☐ Leave a message with detailed information

☐ Leave a message with a call-back number only

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a mobile phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Mindful Dermatology, PLLC, is providing you with the attached notice which provides information about how we may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Mindful Dermatology, PLLC's, Notice of Privacy Practices.

Keeping our patient's information private is important to us and by default, we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that Mindful Dermatology, PLLC, is allowed to disclose this type of information to, please complete the fields below and select the appropriate check boxes based on your approval for each person you list. In addition, please chose a person you would like Mindful Dermatology, PLLC, to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number
☐ **Billing Account Information**	☐ **Medical Condition Information**	☐ **Emergency Contact**

Consent to Treat

I hereby authorize employees and agents of Mindful Dermatology, PLLC, (including physicians, physician assistants, nurse practitioners, other employees & staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Financial Responsibility

I hereby authorize payment of medical benefits directly to Mindful Dermatology, PLLC, and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Mindful Dermatology, PLLC. These amounts could be requested at the time of service and/or by invoice. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Mindful Dermatology, PLLC, if any.

Medicare: You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of your service. You are also responsible for your Medicare annual deductible, as well as any charges for non-Medicare covered or cosmetic services.

Cancellation Policy: You agree to accept responsibility for an office visit charge of $50.00 if you cancel and fail to give 24 hours' notice prior to your appointment.

HMO or Health Select: I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow-up visits if my plan requires. The practice will work to keep you informed of visits remaining on a referral, but ultimately it is my responsibility to maintain a current and effective referral on file through my primary care physician. I understand that failure to obtain a referral, if required, will result in me bearing the complete financial responsibility for any and all services received.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Release & Use of Photographs

Photographs (including digital images) will be taken for treatment documentation purposes. Photographs will become part of the medical record in the patient chart and will be handled in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA). In addition, the undersigned grants the treating physician the ongoing and unrestricted right to use the photographs (but not the patient name) in the ways indicated below.

Your name/identifying information will not be revealed. Please **initial** (consent = yes; non-consent = no) for each specified use:

Yes	No	For medical research, education or science (including medical seminars or journal articles)?
Yes	No	For use during in-office patient consultations?
Yes	No	For use on Mindful Dermatology, PLLC, website?
Yes	No	For social media use, either by Mindful Dermatology, PLLC, or your provider's individual professional social media account?
Yes	No	For external marketing/public relations use (including referral websites and print/television media that provides information about the physician, practice or specific procedure)?

I am at least 18 years of age, and I am competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education. I certify that I have read the above consent form and fully understand its terms.

SIGNATURE SECTION

Patient Last Name	First Name	Middle Name	DOB:

Signature of Patient, Parent or Legal Guardian	Date

Consent to Treat a Minor

I hereby authorize employees and agents of Mindful Dermatology, PLLC, (including physicians, physician assistants, nurse practitioners, other employees & staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Complete this Section ONLY if the Patient is a Minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Parent or Legal Guardian	Date