DARABI
DERMATOLOGY

Patient Information Form

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

Date of Birth:_____ Social Security #:_____ Sex: M / F / Other: _____

Race:	□ Asian	□ Black	□ Hispanic	□ White	□ Decline to Specify
Ethnicity:	□ Latino	□ Non-Latino			□ Decline to Specify
Language:	□ English	□ Spanish	□ Other:		□ Decline to Specify
Marital Status:	□ Single	□ Married	□ Divorced	□ Widowed	□ Other:

Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Preferred Contact Method: □ Phone □ Text □ Email

Emergency Contact:_____ Phone:_____ Relationship:_____

Preferred Pharmacy:_____ Pharmacy Address: _____

Primary Clinic: _____ Primary Doctor's Name : _____

Referring Provider: _____ Town / Facility of Practice: _____

How did you hear about us? □ Provider Referral □ Billboard □ Word of Mouth □ Postcard □ Previous Dr. Darabi Patient

□ Google □ Facebook □ Instagram □ Other: _____

Primary Insurance Carrier: _____ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Policy / ID Number: _____ Group Number: _____

Subscribers Name (If Not Self):_____ Subscriber's Date of Birth (If Not Self): _____

Secondary Insurance Carrier: _____ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Policy / ID Number: _____ Group Number: _____

Subscriber's Name (If Not Self): _____ Subscriber's Date of Birth (If Not Self):

Signature: _____ **Today's Date:** _____

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General Consent and HIPAA Form

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include lab tests, procedures such as biopsies and destructions, and other diagnostic tests. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatment, tests, and procedures and that I have the right to refuse his/her recommendations.

BILLING AUTHORIZATION: I hereby authorize Darabi Dermatology to release requested medical information to my insurance company to collect payment for any charges.

ASSIGNMENT OF BENEFITS: I hereby request that payment of insurance benefits be made directly to Darabi Dermatology on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to services for myself or my dependent. It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay any balances promptly.

MEDICARE AUTHORIZATION: I request the payment of authorized Medicare benefits be made on my behalf to Darabi Dermatology for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as noncovered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those services rendered.

FINANCIAL POLICY: I hereby acknowledge that I had access to a copy of the financial policy of Darabi Dermatology and have been able to review the policy. I know that any co-pay is due at the time of service. I am familiar with Darabi Dermatology policies on insurance benefits, claims, referrals, precertification, and lack of insurance. I am also aware of Darabi Dermatology policies on finance charges and past due balances as well.

PATIENT'S RIGHT TO PRIVACY: I acknowledge I have been made aware of Darabi Dermatology's HIPAA Privacy Practices that pertain to my rights regarding the use and disclosure of my protected health information. These rights are more fully described in this office's Notice of Privacy Practices. I understand a copy of Darabi Dermatology Privacy Practices is available to me on the practice website or in the office upon my request. I consent to be contacted by Darabi Dermatology or other business associates at the physical address, phone numbers and emails provided.

BLOOD TESTING: I understand that while receiving care, a healthcare worker may accidently be exposed to my blood or other bodily fluid. If this rare event occurs, I consent to my blood be tested for the presence of infectious diseases to protect the health care worker.

ELECTRONIC PRESCRIBING: I authorize Darabi Dermatology to retrieve my medication history from my pharmacy through their eprescribing system and then import my current medications into my electronic medical record.

PHOTOGRAPHY: I consent to my pictures being taken for medical records, communication with other health care providers involved in my care, publications, and marketing materials without revealing my identity.

HIPAA Information

I authorize Darabi Dermatology to discuss **all aspects** of my protected health information including but not limited to appointments, medical diagnoses, tests results, prescription information and financial information with the following individuals:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone: _____

Contact Preferences

I wish for Darabi Dermatology to contact me and leave a detailed message with Protected Health Information at the following:

(If you select "No" we would only leave a message stating that we are calling from a doctor's office and to return our call.)

Home Phone Number:	□ Yes	□ No
Cell Phone Number:	□ Yes	□ No
Work Phone Number:	□ Yes	□ No
Other:	□ Yes	□ No

Signature: _____ **Name (Print):**_____ **Today's Date:** _____

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Secure Credit Card on File Policy

Darabi Dermatology requires all patients to keep a credit or debit card on file to pay any out-of-pocket balance due after insurance has made payment to us, or for self-pay patients. After your visit, we will submit a claim to your insurance and await insurance payment. After we receive payment from your insurance and if insurance leaves a portion for you to pay, we will send you a statement for your out-of-pocket responsibility (examples are co-pay, deductible, co-insurance) and await your payment. If no payment is received from you 20 days after the date of the statement, we will charge the card on file the outstanding balance due. This card will be used only to charge the balance due on the patient's account for co-pays, co-insurance, deductibles, no-show fees, returned check fees, interest charges for overdue payments, payment plan installments and other fees listed in our Financial Policy and General Consent.

If you do not have a credit or debit card, we would require a check for $200 made out to Darabi Dermatology to be kept on file.

Itemized receipts will be sent to you for any charges made to your credit or debit card.

We do not physically store your credit or debit card information on paper or on our computers. We only see the last 4 digits and the expiration date of your card. Your card information is kept on file securely with Modernizing Medicine, our secure, cloud-based third-party HIPAA and PCI compliant electronic practice management software provider.

Please provide your credit or debit card to the front desk staff to enter into your electronic chart.

Cancellation Policy
A charge of **$75** will be applied to your account for all office visit appointments that are missed or canceled with less than 24-business-hours notice. A charge of **$250** will be applied to your account for all excision and Mohs surgery appointments that are missed or canceled with less than 48-business-hours notice. For example, Friday 10am is 24 business hours before Monday 10am. Emergencies or no-fault no-shows will be considered on a case-by-case basis.

By signing this form, I authorize Darabi Dermatology to charge any outstanding balances on my account to the credit card, debit card, or check kept on file.

Signature: _____ Name (Print): _____

Today's Date: _____ Staff Witness: _____

For patients with financial hardship or other extenuating circumstances a payment plan can be worked out with the office.