McDonnell Dermatology

Patient Information & Financials

(Please Circle applicable answers)

Name:____ **Status:** Single Married Widowed Divorced Domestic Partner Other

Social Security #______________________________ **Work Status:** Employed Unemployed Retired Student

Date of Birth:_________________________ **Email Address:**________________________________

Gender: **Male** **Female** Preferred Language:___________________________

Ethnicity/Race: **White** **African American** **Asian** **Hispanic** **Not- Hispanic** **Hawaiian or OPI**

Prefer not to say **Other**

PRIMARY Mailing Address: Street Address:____Apt/Unit#:______________

City/State/Zip Code:____

OTHER Mailing Address: Street Address:____ Apt/Unit#:______________

City/State/Zip Code:____

Phone Contact Information: **Primary Phone#:**_________________________ Mobile Home Work

Other Phone#:_________________________ Mobile Home Work

Primary Care Physician:____**Date of Last Visit:**________________________

INSURANCE (Fill out form and present cards to scan)

(NOTE: Tertiary Insurance filing will be the responsibility of the patient)

PRIMARY Ins Company Name:________________________________ **PRIMARY Ins ID#:**__________________________

Insured's Name (If Other than Self):______________________________ **Date of Birth:**______________ **Relation:**___________

SECONDARY Ins Company Name:_____________________________ **SECONDARY Ins ID#:**_______________________

Insured's Name (If Other than Self):______________________________ **Date of Birth:**______________ **Relation:**____________

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, for the purpose of payment of medical claims. I authorize payment of medical benefits to Jonelle K McDonnell MD.

<u>Any laboratory and pathology fees are billed independently of McDonnell Dermatology and are ultimately the patient's responsibility.</u> Payment is required for all services as they are rendered. All applicable co-payments and deductibles will be collected at the time of service as billed. Our Terms are net 30 days.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding whether McDonnell Dermatology/ Dr Jonelle McDonnell is in-network or out of network with my policy. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurances and need for referrals. I am responsible for obtaining any required referrals, and in absence of such will be held responsible for the cost of the service provided.

Signature of Patient:______________________________________**Date:**___________

Or Legal Guardian

Patient HIPAA Consent Form

Preferred and permitted Contacts

PRINT NAME:____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent. This Practice provides this form to comply with the Health Insurance Portability Act of 1996 (HIPAA)

The Patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.**
- **The Practice reserves the right to change the Notice of Privacy Practices.**
- **The Patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.**
- **The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **The Practice may condition receipt of treatment upon the execution of this Consent**

Release of Information (Check or Circle Choices)

☐ **I give permission to be contacted by my listed primary phone#:**________________________

☐ **Can leave detailed medical message** ☐ **Leave call back information only** ☐ **No message at this number**

☐ **I give permission to be contacted by my listed other phone#:**__________________________

☐ **Can leave detailed medical message** ☐ **Leave call back information only** ☐ **No message at this number**

Do you give our office permission to discuss your medical information with another person? YES NO If yes, provide name(s) and phone#(s) below:

Name:__________________________________**Relationship:**_____________ **Phone#:**______________________

Name:__________________________________**Relationship:**_____________ **Phone#:**______________________

Emergency Contact Name:_______________________________ **Phone#:** ____________________

Signature of Patient:___________________________ **Date:**______________

Legal Guardian Printed Name/ Signature:____

Relationship to Patient if other than Patient:____