Aspen Mountain Dermatology

Patient Information

Date _____ Male ☐ Female ☐

Patient (last, first, middle inital)_____

Birthdate _____Social Security # _____ Drivers Lic # _____ State ____

Mailing Address _____City _____ Sate _____ Zip code _____

Street Address_____ City _____ State_____ Zip code _____

(Cell)Phone #_____Home/work phone#_____ Employed by _____

Email Address: _____ Race/ Ethnicity _____

In case of emergency who should be notified/ Relationship to you _____Phone: _____

Who is responsible for this account? _____ Relationship to Patient _____

Mailing Address_____ City _____ state _____ Zip code _____

Cell phone# _____Home/work phone# _____SS# _____

Employer Work phone# _____Birth date _____ ☐ Male ☐ Female

Do you have Medical Insurance? ☐ Yes ☐ No

Name of primary Insurance Company _____

Address of Insurance Company _____

Phone # of Insurance Company _____

Subscriber name _____ID# _____Group # _____
SS# _____DOB _____

Do you have Medicare? ☐ Yes ☐ No Medicare # _____

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Aspen Mountain Dermatology, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission.

Signed _____ Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to provider _____ for any services furnished to me by that physician. I authorize any holder of 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 understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "Other health insurance" is indicated in item 9 of

the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of Medicare Carrier.

Signed _____ Date _____

My health information may be created or received by Aspen Mountain Dermatology and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedure, prescriptions, and similar types of health related information.

I understand that I have the right to receive and review a written description of how Aspen Mountain Dermatology will handle my health information. This written description is known as a **Notice of privacy practices**. And describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Aspen Mountain Dermatology and my right regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of Aspen Mountain Dermatology's **Notice of Privacy Practices** in effect will be posted in the reception area and on our website.

Patients Name (Please print) X _____

Patient's Signature _____ Date _____

[redacted]

SPECIAL PERMISSION REQUEST

I give my permission for Aspen Mountain Dermatology to leave **messages** regarding appointments, billing, treatments, and medical information on any of the following numbers:

_____

Patient's Signature _____ Date _____

I give my permission to have messages regarding appointments, medical and billing information **left with my spouse/partner/caregiver**_____

Aspen Mountain Dermatology

Patient Information

Name of spouse / Partner / Caregiver (Please print)

Patient's Signature _____ Date _____

This release will be revoked by written permission only. I understand that I must send a written request to Aspen Mountain Dermatology in order to revoke this release.

Signature _____ Date _____