****

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Name**\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Records** **#** \_\_\_\_\_\_\_

**Home Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_\_\_\_\_\_\_\_ **ZIP Code**\_\_\_\_\_\_\_\_\_\_\_

**Home Phone Number** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone Number** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Date** \_\_\_ /\_\_\_/\_\_\_ **SSN**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Employer Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your Primary Care Physician?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** Hispanic or Latino Non-Hispanic or Latino Other\_\_\_\_\_\_\_\_\_\_ Declined to answer Ethnicity

**Preferred Language:** English Spanish French Other\_\_\_\_\_\_\_\_\_\_ Declined to Answer Language

**Who may we speak to regarding your medical condition?**

* Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** *Please check all that apply.*

□ Referred by health care provider □ Family/friend recommended □ Google

□ Facebook □ Style Blueprint □Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I**nsurance Information**

* Yes – I have insurance coverage. Please file to the insurance plan listed below.
* No – I have NO insurance coverage and have made payment arrangements.

***Primary Insurance Company Name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Network \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_ /\_\_\_\_ /\_\_\_\_

Relationship to policy holder: Self Spouse Child Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Secondary Insurance Company Name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Network \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_ /\_\_\_\_ /\_\_\_\_

Relationship to policy holder: Self Spouse Child Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I. Treatment of Minors Consent –** Please fill out if patient is under the age of 18.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission to Traceside Dermatology and Allergy to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Mother, Father, Legal Guardian) (Name)

**II. PATIENT PHOTOGRAPHY CONSENT:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Full Legal Name DOB

do hereby consent to all medical images and/or video taken or made of me or my child/dependent by Traceside Dermatology & Allergy, PLC (“Traceside”), and to their use by Traceside for the healthcare and/or promotional purposes indicated below. I understand that Traceside retains the ownership rights to these images, that I am allowed to request copies of the images with a record release, and that that these images will be securely stored and protected. I agree that duplicates may be made and furnished to referring doctors. I agree that the images may be:

(Please initial **YES** or **NO** below to show type of consent) **YES** /  **NO**

* used as part of my chart for physician consultation \_\_\_\_ \_\_\_\_
* used by health professionals for education and training \_\_\_\_ \_\_\_\_
* used in paper or electronic health publications \_\_\_\_ \_\_\_\_
* used in commercial broadcast \_\_\_\_ \_\_\_\_
* used in marketing materials (this includes, but is not \_\_\_\_ \_\_\_\_

limited to, in-office printed marketing materials, Facebook,

Instagram, website, and other online media)

I hereby acknowledge that no promise of compensation for the use of medical photo(s) and or video images was made by Traceside Dermatology and Allergy in exchange for the indicated consent.

This consent maybe revoked at by me any time by written request.

In witness whereof, I have signed this consent in my own hand.

Patient/Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**III. ADVANCED BENEFICIARY NOTICE (for patients with Medicaid secondary insurance only):**

We are not able to bill Medicaid for secondary insurance coverage. If you have Medicaid or a Medicaid managed plan (for example, but not limited to, Amerigroup, BlueCare, United Healthcare Community Plan, TennCare Select) you will be responsible for the portion of the charges that would have been due from Medicaid, after your primary insurance has paid its portion.

**Please review and sign:**

I agree that if I have Medicaid secondary insurance, I am personally responsible for the charges that would have been due from Medicaid or a Medicaid managed care plan.

Patient/Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**IV. RELEASE AUTHORIZATION:**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient 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 restriction. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. 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 in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands and acknowledges that:

• Protected health information may be disclosed or used by the Practice for treatment, payment, or health care operations

• The Practice has a Notice of Privacy Practices and that 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 uses 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 patient or guardian’s execution of this Consent

**V. FINANCIAL POLICIES:**

* Patients will be charged at the time of service for copays and estimated coinsurance. This payment can be made by credit card or check. Please note that any returned checks will incur a $25 fee to cover bank charges.
* As a service to our patients, Traceside Dermatology and Allergy will directly bill your insurance for services rendered. It is your responsibility to provide us with your most current insurance information.
* We try to follow good practices to ensure that the services we recommend are covered; however, if your insurance does not cover a service (for example, office visit, procedure, lab or imaging test) this charge will be your personal responsibility to pay.
* Other service providers connected to your visits with us may bill you separately for the services they provide (for example, lab, imaging, dermatologic pathologist).
* Failure to pay your bill may result in assignment of your account to a collections agency.

**VI. CREDIT CARD ON FILE**

We are committed to making our billing process as simple as possible for our patients. **We require that all patients maintain a valid credit card on file with Traceside Dermatology and Allergy.** At your visit, your card will be swiped to place it on file; it is stored with our secured, cloud-based credit card processor (Billflash), linked to your patient chart. Only the last 4 digits of your card number are visible to us within the system.

After your visit, we will bill your insurance. After your insurance company has paid its portion, we will send you a statement to notify you of any remaining balance. **We will then process your account balance using the card on file two weeks after your statement is sent.** You will receive a confirmation email to the email you place on file. Prior to two weeks, you may pay the balance by check or card if you wish. If your card is declined, we will contact you to obtain updated card information. We require that outstanding balances be paid within thirty (30) days, otherwise your account may be assigned to a collections agency. Finally, all outstanding balances must be paid prior to additional visits at Traceside Dermatology and Allergy.

**Initial Here:**

**\_\_\_\_\_\_\_\_\_**  I have reviewed and agree to the health information release authorization

\_\_\_\_\_\_\_\_\_ I have read and understand, and agree to comply with, the Financial and Credit Card on File policies.

**Print Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient OR Guardian Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_