Welcome to Affiliated Dermatologists, S.C. Skin and Laser Center
Patient Registration

Date _____ Referring Physician/Other_____
Last Name _____ First Name _____M.I._____
Address_____
City_____ State_____ Zip Code_____
Age_____ Birth Date_____ Patient's Employer _____
Telephone: Work _____ Home _____
Cell _____
Emergency Contact _____Phone_____

What is the **Primary** phone number for reminder calls and messages?
(Circle one) Home/ Work/ Cell

May we leave personal medical information on your answering machine/voicemail?
Yes ___ No ___

We would appreciate knowing how and where you heard about us:

____ Mailer
____ Media/ Magazine/ TV/ Radio
____ Insurance Plan
____ Physician
____ Relative/ Friend
____ Signage/ Billboard
____ Website/ Search Engine
____ Other (please specify) _____

Are you interested in receiving promotional information about Aesthetic Services at our Skin and Laser Center?
Email: _____

Our Notice of Privacy Practice 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 agreement.

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 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 (HIPPA).

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 that the patient has the opportunity to review this Noticed
- 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 execution of this Consent.

I understand that I am financially responsible for all charges at The Skin and Laser Center. This authorization is valid until notified otherwise.

Signature of Patient/ Legal Rep: _____Date_____

If signed by person other than patient, state relationship and authority to do so.
Patient is: ☐ Minor ☐ Incompetent ☐ Disabled **Legal Authority:** ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Power of Attorney