EPIPHANY DERMATOLOGY

# *PATIENT REGISTRATION FORM*

## PATIENT INFORMATION

| | |
|---|---|
| *Patient's Legal Name (as it appears on Driver's License or Photo ID):*<br>*First* *Middle* *Last* | *Patient Date of Birth (MM/DD/YYYY):* |
| | *Social Security Number:* |
| *Mailing Address (Street, City, State, ZIP):* | *Patient Gender:* ◯ *Male* ◯ *Female* |
| | *Marital Status:* |
| *Email Address:* | *Occupation:* |
| *Home Phone Number:* | *Employer:* |
| *Cell Phone Number:* | *Employer Phone Number:* |
| *Referred to Clinic By:*<br>*Dr.* _____ ◯ *Family / Friend* ◯ *Insurance Company*<br>◯ *Web Search* ◯ *Print Ad* *Other:* _____ | |
| *Primary Care Physician (PCP) Name:* | *PCP Phone Number (if known):* |

## EMERGENCY CONTACT *(Please list anyone you authorize to receive protected health information)*

| | | |
|---|---|---|
| *Name:* | *Relationship to Patient:* | *Phone Number:* |

## RESPONSIBLE PARTY INFORMATION *(Spouse / Parent / Legal Guardian)*

| | | |
|---|---|---|
| *Guarantor on Account (eg, responsible parent if patient is a minor):* | *Guarantor Phone Number:* | *Guarantor Relationship to Patient:* |
| *Guarantor Date of Birth (MM/DD/YYYY):* | *Guarantor Mailing Address (Street, City, State, ZIP):* | |

## INSURANCE INFORMATION

| | | |
|---|---|---|
| *Primary Insurance Company:* | *Policy/ID Number:* | *Group Number:* |
| *Policyholder's Name:* | *Policyholder's Date of Birth:* | *Relationship to Patient:* |
| *Specialist Copay Amount: $ _____* | | |
| *Secondary Insurance Company:* | *Policy/ID Number:* | *Group Number:* |
| *Policyholder's Name:* | *Policyholder's Date of Birth:* | *Relationship to Patient:* |

## LEGAL INFORMATION

***Assignment of Benefits:*** *The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Epiphany Dermatology and its related companies. I understand that I am financially responsible for any balance. I also authorize Epiphany Dermatology, its related companies, or insurance company to release medical information required to process claims.*

***Notice of Privacy Practices:*** *I have read or been offered a copy of Epiphany Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.*

***Consent for Communication:*** *I understand Epiphany Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.*

***Payment Policy:*** *Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Epiphany Dermatology and its related companies.*

***Late or Missed Appointment Policy:*** *We require a 24-hour cancellation notice if you are not able to keep your appointment. No-show appointments are subject to a no-show fee (including surgery and cosmetics) as missed appointments prevent other patients from seeing our providers in a timely fashion. See office "Late or Missed Appointment Policy" for pricing.*

***Legal:*** *This form applies to Epiphany Dermatology and its related companies.*

***Patient Rights:*** *I have read or been offered a copy of Epiphany Dermatology Patient Rights.*

***Patient Rights Document Received:*** ◯ *Received* ◯ *Declined.*

## SIGNATURE

| | |
|---|---|
| *Patient / Guardian Signature:* | *Date:* |

EPIPHANY DERMATOLOGY

6601 Vaught Ranch Rd, Ste 200
Austin, TX 78730
Phone: (512) 628-0465
Fax: (512) 628-0468

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name (as it appears on DL/State ID): Date of Birth: [DOB]_____/_____/_____

_____

I request and authorize **Epiphany Dermatology** to release healthcare information of the patient named above to:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

**Please send copies of the following Medical Records (check all that apply):**

___ Office Consult notes ___ Pathology report(s) ___ Lab report(s)

___ Entire Medical Records

___Other:_____

I understand the following:
I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization

Patient/Guardian Signature: _____ Date:_____

Exp Date (One year from date of request): _____