

**Gregory & Associates Dermatology, Ltd.**

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**Consent for Release and Use of Confidential Information and  
Receipt of Notice of Privacy Practices Form**

I, \_\_\_\_\_, hereby give consent to Gregory & Associates  
(Name of Patient or Authorized Agent)  
Dermatology, Ltd. ("GAD") to use or disclose, for the purpose of carrying out treatment,  
payment, or health care operations, all information contained in the patient record of  
\_\_\_\_\_  
(Patient's Name)

I acknowledge receipt of GAD's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how GAD may use and disclose my confidential information.

I understand that GAD has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me on my next visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to GAD. I also understand that I will not be able to revoke this consent in cases where GAD has already relied on it to use or disclose my health information. Written revocation of consent must be sent to GAD office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient: \_\_\_\_\_

## CONSENT FORM DEFINITIONS

"Health care operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information.

## BILLING INFORMATION

Payment of insurance co-pay/or for any cosmetic services is expected the day services are rendered. We accept MC/VISA/Discover/American Express/Check/Cash.

**RESPONSIBLE PARTY:** \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone # \_\_\_\_\_ SSN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_ Amount of Deductible/co-pay \_\_\_\_\_  
**Policyholder's Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Member ID# \_\_\_\_\_ Phone # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_  
**Policyholder's Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Member ID# \_\_\_\_\_ Phone # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Gregory & Associates Dermatology, LTD, for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

### ALL INSURANCE AND MEDICARE

I hereby authorize Gregory & Associates Dermatology to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

### NO-SHOW APPOINTMENT POLICY

I hereby authorize Gregory & Associates Dermatology to charge my account \$25.00 if I do not show for a scheduled appointment without calling and cancelling/rescheduling the appointment within 24 hours of the appointment date.

### PROTECTED HEALTH INFORMATION

I hereby authorize Gregory & Associates Dermatology to release or obtain from other physicians and medical facilities whatever records are necessary for my continued care.

### SIGNATURE:

**PATIENT, PARENT OR LEGAL GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

I hereby authorize Gregory & Associates Dermatology to release any medical information for the treatment of my care. **Person(s) to whom information may be disclosed:**

\_\_\_\_\_  
Name of Person/relationship

\_\_\_\_\_  
Name of Person/relationship

### SIGNATURE:

**PATIENT, PARENT OR LEGAL GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

We will provide a full-body skin examination if you choose: Yes / NO (Additional fee may apply and additional time may be required). This service is particularly recommended if you have a history of blistering sunburns, more than 40 moles or if anyone in your family has had skin cancer.

**Full Exam**

- Fevers / Chills / Weight loss? Yes / NO
- Sore eyes / Dry eyes? Yes / NO
- Sores in mouth or nose? Yes / NO
- Chest Pain / Leg swelling? Yes / NO
- Nausea / Diarrhea? Yes / NO
- Burning urination/Frequent urination? Yes / NO
- Muscle or joint pain? Yes / NO
- Numbness of feet / Dizziness? Yes / NO
- Depressed / Anxious Mood? Yes / NO
- Fatigue / Cold Intolerance? Yes / NO
- Swollen lymph glands? Yes / NO
- Runny nose / Stuffy head / Asthma? Yes / NO

Do you have any recent problems with the following? If yes, please describe in this space.

**Review of Systems**

- Family History of Skin Cancer
- Family Diseases
- Illicit Drug Use
- Smoking History
- Alcohol Intake
- Do You Have Any Artificial Joints? Yes / NO
- Mitral valve prolapse or artificial heart valve? Yes / NO
- Past Surgeries
- Chronic Illness
- Current Medication
- Drug Allergies

**Past / Family / Social History**

- Name
- City
- Street
- Home Phone
- Work Phone
- Cell Phone
- Patient SSN
- Occupation
- Employer
- Emergency contact: Other than spouse / parent
- Name
- Phone #
- Referred by whom?
- Spouses / Parent's Name
- Spouses / Parent's Employer
- Personal Physician
- Date of Birth
- Male or Female

**PATIENT REGISTRATION**

Date: \_\_\_\_\_ (please print) Acct: \_\_\_\_\_