MEDICAL RECORD # _____ DR. BEING SEEN _____ DATE _____

Advanced Dermatology Center, P.C. **REGISTRATION FORM**

PATIENT INFORMATION

REFERRING PHYSICIAN'S NAME _____

NAME LAST	FIRST	M.I.	EMAIL ADDRESS

MAILING ADDRESS	CITY	STATE ZIP CODE	HOME PHONE
			( )

SOCIAL SECURITY #	SEX M F	DATE OF BIRTH MO. - DAY - YR.	MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	CELL PHONE
				( )

EMPLOYER'S NAME AND ADDRESS	CITY	STATE ZIP CODE	WORK PHONE
			( )

RESPONSIBLE PARTY

☐ **IF SAME AS ABOVE CHECK HERE**

NAME LAST	FIRST	M.I.	DATE OF BIRTH MO. - DAY - YR.

MAILING ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP

RESPONSIBLE PARTY'S EMPLOYER NAME AND ADDRESS	CITY	STATE	ZIP CODE

RESP. PARTY HOME PH.#	RESP. PARTY WORK PH. #	RESP. PARTY'S SOC. SECURITY #
( )	( )	

ASSIGNMENT OF BENEFITS - AUTHORIZATION TO RELEASE INFORMATION - FINANCIAL RESPONSIBILITY

WITH MY CONSENT **ADVANCED DERMATOLOGY CENTER, P.C.** MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO).

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. **ADVANCED DERMATOLOGY CENTER, P.C.** RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO **ADVANCED DERMATOLOGY CENTER, P.C.** PRIVACY OFFICER, 710 ST ANNE STREET, RAPID CITY, SD 57701

ADVANCED DERMATOLOGY CENTER, P.C. MAY CALL ☐ HOME ☐ WORK ☐ CELL

LEAVE VOICEMAIL OR MESSAGE ON ANSWERING MACHINE ☐ YES ☐ NO

MAY DISCUSS HEALTH INFORMATION WITH FAMILY ☐ YES ☐ NO

I HEREBY ASSIGN ALL MEDICAL/SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLAN TO: **ADVANCED DERMATOLOGY CENTER, P.C.**

THIS ORDER WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT AND TO COMPLETE DISABILITY FORMS PRESENTED TO ME.

SIGNED _____ DATE _____