Arkansas Dermatology Patient Registration
(Please Print)

Today's Date: ___________________

Patient's Name: ____

Please list your name exactly how it reads on your insurance card

DOB:____________________________ **SSN:** __________________________________

Mailing Address: ____

City: _________________________ **State:** __________ **Zip:** ____________

Contact Number: Primary (_____) ____
Home Cell Work

Secondary Contact Number: (_____) ____
Home Cell Work

Emergency Contact:____________________________(_____) ___________________________
(Name) (Phone number)

Responsible Party (if patient is a minor): ____

<u>Primary:</u>
Insurance Carrier name: ____

ID:________________________________**Group #:** ___________________________________

Subscriber: Self or ____

Subscriber's Address: (If different than above) ____

DOB:_____________________ **SSN:** ___________________________________

<u>Secondary:</u>
Insurance Carrier Name: ____

ID:________________________________**Group #:** ___________________________________

Subscriber: Self or ____

Subscriber's Address: (If different than above) ____

DOB:_____________________ **SSN:** ___________________________________

I understand Arkansas Dermatology will only file two insurance carriers and they are to be filed as indicated. I also understand that all copays are due upon check in before services are rendered.
Initial: __________

Signature: ____
I understand & agree that regardless of the insurance status, I am responsible for the balance on this account for any services rendered. I certify that all the above information is true and correct. I understand it is my responsibility to notify Arkansas Dermatology of any changes in the above information. By not signing, I am agreeing to remit payment in full for all services provided by the staff.

Arkansas Dermatology HIPAA
Authorization Form
(Please print)

Date: __________________

Patient's Name: ____

DOB:_____________________________ **Email:** _______________________________________

I,____**have received a copy of the Arkansas Dermatology Notice of Privacy Practices.**

I authorize Arkansas Dermatology to disclose my PHI (Protected Health Information) to the following providers and (or) facilities in regards to my treatment.

Primary Care Provider (PCP):

Name:____________________________________**City:** __________________________________

Referring Provider:

Name:____________________________________**City:** __________________________________

Additional Providers or Facilities:

Name:____________________________________**City:** __________________________________

Name:____________________________________**City:** __________________________________
(If you do not authorize the release of your information leave the above blank and sign below)

I authorize Arkansas Dermatology to disclose my PHI (Protected Health Information) to any person(s) indicated other than providers. This would include family, friends, guardian, POA……

Name:_____________________________________**Phone:** ________________________________

Name:_____________________________________**Phone:** ________________________________

Name:_____________________________________**Phone:** ________________________________
(If you do not authorize the release of your information leave the above blank and sign below)

Signature: ____
By signing I certify that all the above is true & correct. I understand I have the right to revoke this authorization at any time and that it is my responsibility to request a new HIPAA form to make changes should any occur. By providing an email address, you are consenting to receive communication via unencrypted email.