PACIFIC SKIN INSTITUTE

PATIENT REGISTRATION FORM

(Please print the **PATIENT'S** Information)

Patient's

First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ M ☐ F Preferred Pronoun: _____ Birth Date: _____/_____/_____ Social Security #: _____

Home Phone: (_____) _____ Work: (_____) _____ Mobile: (_____) _____

Preferred Phone # ☐ Home ☐ Work ☐ Mobile Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

How did you hear about us? ☐ PCP ☐ Google ☐ Facebook ☐ Instagram ☐ Sacramento Magazine ☐ Other:_____

_____

Email: _____ Height:_____ft_____in Weight: _____lbs

Race/Ethnicity (Please circle one):

Hispanic/Mexican	Caucasian	Filipino	American Indian	Samoan	Korean	Asian Indian	Asian	Pacific Islander
Black/African American	Puerto Rican	Cuban	Native Hawaiian	Japanese	Chinese	Vietnamese	Guamanian	Other

Preferred language if not English: _____ PCP/Referring Doctor: _____

1) Primary Insurance: _____ ID # _____

Subscriber Name: _____ Relation to Patient:_____ Birth Date:____/____/____

2) Secondary Insurance: _____ ID # _____

Subscriber Name: _____ Relation to Patient:_____ Birth Date:____/____/____

Preferred Pharmacy: _____ Preferred Lab: ☐ Sutter ☐ Quest ☐ Other _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Please Acknowledge:

Phone calls and prescription refills will be addressed and returned by the provider or a member of their team within 2-3 business days from the date of receipt. Initial _____

HIPAA Acknowledgement: I have received and read Pacific Skin Institute's Notice of Privacy Practices. In my absence or for the benefit of gaining medical advice on my behalf, I authorize the following persons to gain Patient Health Information for or with me:

_____

(Please list authorized Representative (s) or mark N/A)

Do we have your permission to:

Leave a message on your answering machine or cell phone? YES or NO

Contact you via email? YES or NO

Discuss your medical conditions with any member of your household? YES or NO

Authorization, Consent of Professional Services and Release of Information: I hereby authorize Pacific Skin Institute to provide insurance companies or their representatives information concerning my (or my dependents) illness and treatments and I hereby assign to Pacific Skin Institute, PC all payments for medical services rendered by myself or my dependents. Necessary forms will be completed to expedite carrier payments, however the balance of any uncovered services are charged to the patient . All copays, deductibles and known uncovered services/treatment provided to you as a patient of Pacific Skin Institute are payable at the time of service and are the sole responsibility of you "the patient" and/or guarantor of "your children". ***I understand that I am responsible for any amount not covered by insurance*.**

I hereby authorize and release the Medical Provider and whomever he/she may designate as an assistant to administer treatment, physical exam, imaging, laboratory procedures, or any medical service that he/she deems necessary in my case, and I further authorize him/her to disclose all or part of my patient record to any person/corporation which may be liable under contract to the clinic, the patient, a family member or employer of the patient, including but not limited to hospital or Medical Services Company, Insurance Company, Welfare Funds, or the patient's employer.

I understand that Pacific Skin Institute, as a comprehensive Skin Care/Dermatology Practice, believes in the value of cutting edge Clinical Research and advancing medical education. I understand that clinical trials are available to me outside of my medical care and insurance coverage through Integrated Skin Science Research (ISSR). I understand that as a premier center for advancing medical education, on occasion, Medical and Physician Assistant students and residents may be involved in my medical care team.

Patient Information Consent: I understand that Pacific Skin Institute may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment, for obtaining payment, and for the purpose of operating the Practice. I consent to the use of my information for the purpose of treatment, payment and healthcare operations.

I understand that my consent is not needed if the law requires Pacific Skin Institute to report some aspect of my protected health information to a Government Agency (I.E. suspected abuse, communicable disease and potential bodily harm to myself or others).

I understand that I have the right to review Pacific Skin Institute's Privacy notice, to request restrictions be put on the use of my information, and to revoke my consent at a later date. I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operation, **Pacific Skin Institute may refuse to undertake my care.**

I hereby consent to the following: Administration and performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, administration of any needed anesthetics, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies and surgery, performance of other medically necessary and accepted laboratory tests that may be advisable based on the judgement of the attending physician or their assigned designee. I intend this consent to be continuing in nature even after a specific diagnosis and treatment recommendations. The consent will remain in full force until revoked in writing. I understand that Pacific Skin Institute may include consent at satellite offices under common ownership.

Medicare Patients: I authorize the release of my medical information about me to the Social Security Administrators or its intermediaries for my medical claims. I assign the benefits payable for services to Pacific Skin Institute.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content. I certify that all of the information provided above is true and correct to the best of my knowledge.

Patient (or Guardian) Signature **Date**

Reschedule/No Show Policy: As a patient, you are responsible for keeping your appointments. If patients are unable to keep their scheduled appointment, we ask that you show consideration by contacting our office 24 hours in advance to cancel or reschedule their appointment. We would like to have the option to offer that appointment to other patients in need.

1st No Show: Will be noted in your chart _____ Initials
2nd No Show: Patient will be asked to return to their PCP to get a new referral. _____ Initials
3rd No Show: Patient could be dropped as a patient from Pacific Skin Institute. _____ Initials

Late Policy: If you are more than 15 minutes late to your appointment, you will not be seen. You will need to reschedule your appointment, and it will be noted in your chart as a "No Show".

Your signature below is an acknowledgment of these policies. A copy will be placed in your chart and can be provided upon request.

Signature: _____ **Date**:_____

Printed Name: _____