PACIFIC SKIN INSTITUTE

PATIENT REGISTRATION FORM

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

Patient's
First Name: _____ Middle: _____ Last: _____

If patient is a minor, please provide: Guardian's Name: _____ Guardian's DOB: _____

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

Gender: ☐ M ☐ F 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: _____

Emergency Contact:

Name: _____ Relation to Patient: _____ Phone # (_____) _____

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

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 time that your call was made.

Initial_____

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF PACIFIC SKIN INSTITUTE ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN".

I HERBY AUTHORIZE PACIFIC SKIN INSTITUTE TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO PACIFIC SKIN INSTITUTE, PC ALL PAYMENTS FORMEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS.

I UNDERSTAND THAT I AM **RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE**.

I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANYCLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THEPATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

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 FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE 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 (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW PACIFIC SKIN INSTITUTE PRIVACY NOTICE, TOREQUEST 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 OPERATIONS, **PACIFIC SKIN INSTITUTE MAY REFUSE TO UNDERTAKE MY CARE**.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. 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 TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATIONOR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TOPACIFIC SKIN INSTITUTE

HIPAA ACKNOWLEDGEMENT: I HAVE RECEIVED AND HAVE READ PACIFIC SKIN INSTITUTE NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON 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
Would you like to be added to our monthly newsletter to be informed of:	YES or NO

- PSI Highlights and promotions
- Skin Tips
- PSI Updates i.e., holiday clinic hours

CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT, ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

_____

PATIENT (OR GUARDIAN) Signature Date