MACIAS DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

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PATIENT INFORMATION

Patient First & Last Name:_____ Sex: (circle) M / F

Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number (optional): _____- _____- _____Date of Birth: ____ / ____ / _____ Marital status: S M D W

Phone Number: (circle preferred) Home: _____ Cell: _____
E-Mail: _____

Who to notify in case of **emergency**? _____ Relationship: _____

Daytime Phone Number: _____ Alternate Phone Number: _____

Race: (circle) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Other Race / Declined to State

Ethnic Group: (circle) Hispanic or Latino / *Not* Hispanic or Latino / Declined to State / Other: _____

INSURANCE INFORMATION

Primary: _____ / Secondary: _____

Primary Responsible Party's Name: _____ Date of Birth: ____ / ____ / ____
If applicable:
Secondary Responsible Party's Name: _____ Date of Birth: ____ / ____ / ____

Patient's Relationship to Insured: (circle) Spouse / Child / Other: _____

REFERRAL INFORMATION

How were you referred to our practice? (circle): Friend _____ / Physician / Insurance / Facebook / Instagram / Website / Search Engine

If applicable:
Primary Care Physician: _____ Referring Physician: _____

I hereby authorize the above information is correct.

Patient/Responsible Party Signature: _____

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PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to the physician/practice individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Macias Dermatology is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the patient information Privacy Policy. I hereby
Authorize to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risk and complication are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.

ACKNOWLEDGEMENT:
My signature below acknowledges that I have read and understand the disclosures & consents.

Patient Signature: _____ Date: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT_____

GUARANTOR SIGNATURE: _____ DATE: _____

(If different from patient)

7115 N. Chestnut Ave. Suite 101 | Fresno, CA 93720 (559) 431-2397

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program.

These include:
• Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the patient's drug benefit plan.
• Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize adverse drug events.
• Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Macias Dermatology, can electronically transmit your prescriptions directly to your pharmacy.

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payors (i.e., your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to Macias Dermatology to enroll me in the E-Prescribe Program.

_____ _____
Signature of Patient (or Guardian) Date of Birth

_____ _____
Print Patient Name Relationship to Patient

If you choose to participate in E-Prescribing, please list your preferred pharmacy information below.

_____ _____ _____
Pharmacy Name **Location (City and Street Name)** **Pharmacy Telephone Number**

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your Insurance
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment and send a bill for any amount that is deemed Patient Responsibility by your insurance carrier.

If your insurance requires a referral it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.

If you have Medicare, PART B only you are responsible for your Medicare deductible and your 20% of the charges will be billed to you.

If you are being seen as a Self-Pay patient, charges for your care and treatment are due at the time of the service.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

In the event that your health plan determines a service to be **"not covered,"** you will be responsible for the complete charge and a bill will be sent to you.

We will bill your health plan for all services provided. Any balance due is your responsibility and is due at the time of service or upon the receipt of a statement from our office.

If you have lab work performed, you will receive a separate bill from the lab offices that prep and provide lab results.

Macias Dermatology charges a fee for failure to cancel your appointment within 24 hours of your scheduled appointment $25.00 for office visits $50.00 for scheduled surgeries.

RETURN POLICY
NO REFUNDS. STORE CREDIT WITHIN 14 DAYS WITH RECEIPT FOR UNOPENED, UNUSED PRODUCT ONLY.

COSMETIC SERVICES RETURN POLICY
NO REFUNDS FOR PRE-PAID SERVICES OR PACKAGES.

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of the Notice of Privacy Practices

Patient Name: _____
Birthdate: _____

Address: _____ Telephone No. _____
_____
_____

I hereby acknowledge that I have reviewed Macias Dermatology's Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Macias Dermatology may use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact the Medical Director if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Macias Dermatology.

_____ Date_____
Signature of Patient or Patient's Representative

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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above --

(Check either A or B):

- ❑ A. **Disclose** my complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ❑ B. **Disclose** my health record, as above, **BUT do not disclose** the following

Other (please specify):

_____

_____

This authorization shall be effective until (Check one)

- ❑ All past, present, and future periods, OR
- ❑ Date or Event _____

Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)

_____ _____

Name of the Individual Giving this Authorization Date of Birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R.