

**P: 623-243-9077 F: 623-271-9826**

|  |  |
| --- | --- |
| Today’s Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |  |
| PATIENT INFORMATION |
| Patient’s Last Name | First | Middle | ❑ Mr. ❑ Mrs. | ❑ Miss❑ Ms. | Marital Status (Circle One) |
|  | Single / Mar / Div / Sep / Wid |
| Is this your legal name? | If not, what is your legal name? | (Former Name) | Birth Date | Age | Sex |
| ❑ Yes | ❑ No |  |  |  / / |  | ❑ M | ❑ F |
| Street Address |  | Social Security | Cell Phone: Home Phone:  |
|  | ( ) | ( ) |
| City  | State Zip code |  Email: |  |
|  |  |  |  |
| Occupation | Employer | Employer Phone No. |
|  |  | ( ) |
| Chose Office Because/Referred to Office by (Please check one box) | ❑ Dr.  |  | ❑ Insurance Plan | ❑ Hospital |
| ❑ Family | ❑ Friend | ❑ Close to Home/Work |  | ❑ Other |  |
|  |
| Other Family Members Seen Here |  |
|  |
| INSURANCE INFORMATION | **(please give your insurance card to the receptionist)** |
| Person Responsible for Bill | Birth Date | Address (if different) | Home Phone No. |
|  |  / / |  | ( ) |
| Is this person a patient here? | ❑ Yes | ❑ No |  |
| Occupation | Employer | Employer Address | Employer Phone No. |
|  |  |  | ( ) |
| Is this patient covered by insurance? | ❑ Yes | ❑ No |  |
| Please indicate primary insurance |  |
|  |
|  |
| Subscriber’s Name | Subscriber’s S.S. # | Birth Date | Group # | Policy # | Co-Payment |
|  |  |  / / |  |  | $ |
| Patient’s Relationship to Subscriber | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
|  |
| Name of Secondary Insurance (if applicable) | Subscriber’s Name Subscriber Birth Date | Group # | Policy # |
|  |  |  |  |
| Patient’s Relationship to Subscriber | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
|  |  |  |  |
|  |
| IN CASE OF EMERGENCY |
| Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone No. | Work Phone No. |
|  |  | ( ) | ( ) |
|

|  |
| --- |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLL; DBA Regency Plastic Surgery or insurance company to release any information required to process my claims. |
| PATIENT/GUARDIAN SIGNATURE | DATE |

 |

**Medical History**

|  |  |
| --- | --- |
| □ ***Medical History:**** Acne
* Actinic Keratoses
* Asthma
* Basal Cell Skin Cancer
* Blistering Sunburns
* Dry Skin
* Eczema
* Flaking or Itchy Scalp
* Hay Fever/Allergies
* Melanoma
* Poison Ivy
* Precancerous Moles
* Psoriasis
* Squamous cell skin cancer
* Adrenal Insufficiency
* Anemia/Thalassemia
* Anxiety
* Arthritis
* Asthma
* Atrial Fibrillation (Irregular Heartbeat)
* Auto-Immune Disease
* Bipolar Disorder
* Blood Clotting Disorder
* Bone Marrow Transplantation
* BPH
* Breast Cancer
* Colon Cancer
* COPD
* Coronary Artery Disease
* Deep Venous Thrombosis

**Do you have a family history of Melanoma?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**History or Family history of Malignant Hyperthermia and Anesthesia Sensitivity? \_\_\_\_\_\_\_\_\_\_\_****Personal or Family history of Breast cancer? \_\_\_\_\_\_\_\_\_****Do you have a health care proxy in the event you are unable to make your own medical decisions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Do you have a living will? \_\_\_\_****Which statement best reflects your wishes on advanced care recommendations?*** **Do Not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.
* **Do Not Resuscitate**: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
* **Full Cardiopulmonary Resuscitation**: I want full

cardiopulmonary resuscitation efforts to be made***Allergy to medication: Reaction:******\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_******\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_******\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | * Depression
* Diabetes
* Easy Bruising
* End Stage Renal Disease
* GERD
* Head Trauma
* Hearing Loss
* Hepatitis
* Hypertension
* HIV / AIDS
* Hypercholesterolemia
* Hyperthyroidism
* Hypothyroidism
* Leukemia
* Lung Cancer
* Lupus
* Lymphoma
* Malignant Hypertension
* Mental Health Hospitalization
* Neuromuscular Disorder
* Paralysis
* Pneumothorax
* Prostate Cancer
* Pulmonary Embolism
* Radiation Treatment
* Renal Disorder
* Rheumatoid Arthritis
* Seizures
* Severe Reaction to Anesthesia
* Stroke
* Trauma
* Valvular Heart Disease
* Vision Loss
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***□ For Female Patients:***○ Are you pregnant/Planning Pregnancy□ ***Other/Not Listed:***○ Transplant? Y N. What Type? \_\_\_\_\_\_\_\_\_ ○ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Current Medications (Including Herbal medications)******\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*****Past Surgical History** Surgery: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Social History**□ Smoker: \_\_ Packs/day □ Non-smoker □ Quit smoking□ Smokeless Tobacco: □ Y □ N□ Alcohol use: □ Yes (drinks/week: \_\_\_ □ No□ Sunscreen use: □ Regularly □ Rarely □ Never □  ***Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  |

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone: H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Above listed patient authorizes the following healthcare facility to make record disclosure:

|  |  |
| --- | --- |
| **Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****City, ST, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **The purpose of disclosure is:** **• Change of Insurance or Physician** **• Continuation of Care** **• Referral****Dates and Type of information to disclose:** * **Dates Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Specific Information Requested:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **Facility Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Facility Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**This information may be disclosed and used by the following individual or organization:**

**Release To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax records.**  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosed and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient / Parent / Guardian or Authorized Representative

(Guardian or Authorized Representative must attach documentation of such status.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Authorized Representative

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Protected Health Information Release Form:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(1) Concerning matters of my health, I give permission for Dr. Hinderks Davis, Dr. Jason Mussman or a member of her/his staff to speak with:

Name of person(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?

 YES NO

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

 Primary Doctor’s Name:

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Referring Provider:

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Pharmacy:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND FINANCIAL POLICIES**

**I. Consent for treatment:** I authorize Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery its agents, Betty Hinderks Davis, MD Jason Mussman, MD, and Benjamin Jones , MD. to render treatment to me/my dependents for dermatological and medical/surgical care.

**II. Assignment of Benefits/Release of medical information:** I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery for services provided under their care. I also authorize Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

**III. Digital Photography:** I authorize the physicians/staff of Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery to take digital photographs that relate to my care. Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery will only disclose information relevant to my care to permitted persons and any and all physicians who care for me. The photographs may be used for teaching, academic and research purposes so long as my identity is concealed.

**IV. Financial Responsibility:** When we bill your insurance company, any deductible and co-insurance charges will apply. Any payment that you make on your visit will be credited to your account. Once the insurance company makes payment, you will be responsible for any and all remaining balances. Please note that ANY procedure performed in our office may be applied to a surgical deductible or co-insurance. Surgery is considered anything that breaks skin – this includes injections/destruction of lesions and biopsies. We do not verify outside benefits, therefore any outside services such as lab, anesthesiology and facilities services that are ordered and/or performed at your visit will be submitted to your insurance by the outside facilities. **You may receive separate billing from the outside facilities.**

\*A healthcare deductible is the amount that you must first pay before your insurance will make any payment. Once you have met the full amount of your deductible, your insurance company will then make payment on future visits to any healthcare provider. The deductible must be paid every year, usually beginning January 1st.

\*\*Once your deductible is met, many insurance companies still do not pay 100% of the healthcare cost. If that is the case you will have a copay or co-insurance, which is a partial payment required by you in addition to what the insurance company will pay. It can be from 10-50% of the allowed amount until you have accumulated enough medical bills to meet your yearly out-of-pocket maximum.

**\*\*\*This is an estimated portion that is due. Unfortunately we don’t know exactly what your insurance will cover or what you will be billed until your claim is processed**.

If you have any questions regarding your financial responsibilities please ask or call our billing department at **Regency Dermatology:** 623-271-9261 **Regency Plastic Surgery:** 623-322-0730

**V. Referrals/Authorization:** I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

**VI. Missed Appointments:** Our office requires 24 hour notice for cancellations. Patients who fail to show to the **initial** visit will be forgiven, If a patient chooses to schedule a second appointment we will place a credit card on file and If the **second** appointment is missed we will process the credit card on file for $75.00 (non refundable). If a **third** no show or cancellation/reschedule with no 24 hour notice should occur the patient will be charged $90.00. If a **fourth** should occur the patient will be charged $100.00 and be dismissed from Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery.

 **I have reviewed the statements above and understand my responsibilities and if I don’t understand my responsibilities, I agree that I can ask questions!**

Patient or Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HIPAA COMPLIANCE STATEMENT**

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,**

**AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

At Regency Skin Institute PLLC; DBA Regency Dermatology and/or Mussman PLLC; DBA Regency Plastic Surgery we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

# UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

# Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

# YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

# OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

# OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM If you have concerns or would like additional information, you may contact the practice’s Office Manager at (623)243-9077.

Patient or Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Disclosure

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non- routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(gg). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

You are being referred to/from (Regency Dermatology/Regency Plastic Surgery) to (Regency Dermatology/Regency Plastic Surgery). While A.R.S. §32-1401(27)(gg) may not directly apply depending on the referral source, (I/we) wish to advise you of Dr. Mussman’s financial interest in these entities so that you can make an informed decision about your care.

Regency Dermatology is a trade name owned by Regency Skin Institute, PLLC. Dr. Jason L. Mussman owns, controls and has a financial interest in Regency Skin Institute, PLLC.

Regency Plastic Surgery is a trade name owned by Mussman, PLLC. Dr. Jason L. Mussman, as Co-Trustee of the Mussman Family Living Trust, owns, controls and has a financial interest in Mussman, PLLC.

Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS

Dermatology

• Beatrice Keller Dermatology

• Omni Dermatology

• Affiliated Dermatology

Plastic Surgery

• Biswas Plastic Surgery

• Richard J Brown Plastic Surgery

Surgery Centers and Hospitals

• Estrella Outpatient Surgery Center

• Abrazo West Hospital

• Banner Del Webb Hospital

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy.

ACKNOWLEDGEMENT: (I/We) have read this “Notice to Patients” form, and (I/We) understand the disclosures that it contains.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_