Bakersfield Dermatology and Skin Cancer Medical Group

5101 Commerce Drive, Suite 101, Bakersfield, CA 93309
661-327-3756

Date_____/_____/_____ **Account Number**_____
(Office Use Only)

Patient Information:

Patient Name_____ **DOB**_____/_____/_____ **Age**_____
First MI Last
Mailing Address_____ **City/State/ZIP**_____

Home Ph.(_____)_____-_____ **Cell Ph.** (_____)_____-_____ **Referring Doctor**_____

Driver's License (Parent)_____ **Gender**_____ **Social Security Number**_____-_____-_____

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Preferred Language:** ☐English ☐Spanish ☐Other

E-mail address:_____ ☐ Decline e-mail, please.

Please answer the following questions:

May we leave information on your answering machine regarding your visit, appointments, treatments, etc.? YES NO

Have you ever been a patient in our office? YES NO **If yes, when?** _____/_____

Have other members of your family been patients in our office? YES NO **If yes, who?**_____

Consent to Treat a Minor:

I hereby authorize Bakersfield Dermatology (the Provider) to administer medical treatment or care as deemed medically necessary to my _____ (please indicate the minor's relationship to the guardian).

_____ _____ _____/_____/_____
(Name of Legal Guardian) (Signature of Legal Guardian) (Date)

Parent/Legal Guardian:

Mother_____ **DOB**____/____/____ **SSN** _____-____-_____
First MI Last
Address (If different than patient) _____
Street City/State/ZIP
Mother's Employer_____**Home/Work Phone** (____) ____-_____

Father_____ **DOB**____/____/____ **SSN** _____-____-_____
First MI Last
Address (If different than patient)_____
Street City/State/ZIP
Father's Employer_____**Home/Work Phone** (____) ____-_____

Stepparent information (If applicable) Name:_____ **DOB**_____/_____/_____

Please provide the following information as completely as possible:

Primary Insurance_____ Subscriber Number_____ Group Number_____

Subscriber Name_____ DOB____/____/____Relationship to Patient: Self Spouse Parent Other

Secondary Insurance_____ Subscriber Number_____ Group Number_____

Subscriber Name_____ DOB____/____/____Relationship to Patient: Self Spouse Parent Other

I have received the HIPAA notice of Privacy Practices, and the Insurance and Payment Policies of Bakersfield Dermatology. I authorize payment of insurance benefits and release of Protected Health Information (PHI), in accordance with HIPAA Regulations.

_____ _____
Patient (or Guardian, if patient is under 18) Signature **Date**
(Signature valid for three years from your handwritten date on this document, unless otherwise specified.)

BAKERSFIELD DERMATOLOGY & SKIN CANCER MEDICAL GROUP
(voluntary)
PERMISSION FORM

Date:_____

I, _____, give permission for

_____/ _____
(Name) (Relationship)

_____/ _____
(Name) (Relationship)

to accompany my child/children as listed below to any scheduled appointments in my absence. This person **must** be 18 years of age or older.

_____
(Name & date of birth of patient(s))

Signature:_____

BAKERSFIELD DERMATOLOGY & SKIN CANCER MEDICAL GROUP
5101 COMMERCE DRIVE, SUITE 101
BAKERSFIELD, CA 93309
(661)327-3756

BAKERSFIELD DERMATOLOGY & SKIN CANCER MEDICAL GROUP
5101 COMMERCE DRIVE SUITE 101
BAKERSFIELD, CA 93309
661-327-3756

HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

Printed Patient Name: _____
Patient Date of Birth: _____
Chart Number: _____

Bakersfield Dermatology & Skin Cancer Medical Group is required by law to maintain the privacy of and provide individuals with the attached Notice of our Legal Duties and privacy practices with respect to protected health information. If you would like a copy of this Notice, please ask.

I hereby acknowledge that I have received and reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____
Printed name of patient or patient's representative/parent

_____
Relationship to patient

08/2013

Bakersfield Dermatology & Skin Cancer Medical Group

5101 Commerce Drive, Suite 101, Bakersfield, CA 93309
661-327-3756

HIPAA NOTICE OF PRIVACY PRACTICES

WE ARE MANDATED BY FEDERAL LAW TO NOTIFY YOU OF YOUR RIGHTS AND OBTAIN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS DOCUMENT. THIS IS FOR ALL OF OUR PATIENTS. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

In order to meet the legal requirements of the Health Insurance Portability and Accountability Act (HIPAA), Bakersfield Dermatology must describe its uses and disclosures of protected health information (PHI). The law allows Bakersfield Dermatology to disclose PHI for the purposes of treatment, payment, and health care operations. These three items are referred to collectively as TPO. TPO may include information such as chart notes, laboratory reports, medical history, diagnoses, insurance coverage, payment history, and demographic information but is not limited to these examples. HIPAA requires that we inform you of all the uses and disclosures of your PHI required or allowed by law. This notice informs you that we may disclose your PHI in the course of TPO in written, electronic, and oral formats as necessary for your medical needs, insurance requirements, payments to your account, and the health care operations of this practice. Disclosures will likely be made to insurance companies, other physicians' offices, medical laboratories, and pharmacies as required for your medical needs, payment and the routine health care operations of this practice. All of the possible disclosures described in this notice are part of the routine function of a medical practice; only HIPAA now requires us to inform you of them. The HIPAA law also requires us to maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI. This notice of privacy practices (NPP) constitutes notice of these legal duties and privacy practices. All of our employees are required to sign confidentiality agreements upon hiring. They are trained in the proper use and disclosure of PHI and practice discreet methods of communication in order to maintain your privacy. We are required by law to abide by the contents of this NPP.

From time to time legal requests (i.e. subpoenas and court orders) are made for copies of patient records. This does not often occur, however Bakersfield Dermatology will abide by any court instructions to provide such information as required by law. Judicial and legal requests from law enforcement are not covered under the HIPAA law. However unlikely, HIPAA requires that we inform you of this possibility.

We may disclose PHI to a business associate. A business associate is a person or entity, other than a member of the workforce of a covered entity, who performs functions on behalf of Bakersfield Dermatology. All of our business associates are obligated, under contract with us to protect the privacy and ensure the security of your PHI.

Bakersfield Dermatology may contact you for appointment reminders, information regarding your account, health benefit information, treatment alternatives, and services that may be of interest to you.

You have a right to be notified if the practice discovers a breach of your PHI.

You have the right to restrict the disclosure of your PHI to your health plan, however, you will have to have paid in full on an out of pocket basis.

You have the right under the HIPPA law to examine and request copies of and amendments (not changes) to your medical records and to request restrictions on the uses and disclosures of your PHI, such as a restriction to send PHI to a specific physicians office or pharmacy. However, the law does not require that we agree to the request. You also have the right to request an alternate form of communication for your PHI, such as mailing instead of faxing. You have the right to receive an accounting of disclosures that are unrelated to TPO. We reserve the right to charge you for copies made on your behalf at this facility and require that one of our staff make any copies requested.

You have the right to opt out of fundraising or marketing communications at the time of solicitation.

Bakersfield Dermatology reserves the right to revise and change the terms of its NPP. A revised or current NPP will be made available upon request to all patients. All patients receive the current NPP on their initial visit. Patients may file a complaint to Bakersfield Dermatology in the form of a signed letter to the address at the top of this notice. Patients may also complain directly to the secretary of the Department of Health and Human Services (HHS). There will be no retaliation against you for filing a complaint. To discuss any and all matters contained in this NPP or for further information contact the practice's office manager at 661-327-3756. HIPAA requires that an expiration date be included on this notice; that date will be 3-years from the date you signed for the Records Release.

Effective Date: September 1, 2013 BD044b0813