First Name:	Last Name:	
Patient DOB:	SSN:	
Address:		
City:	State:	Zip Code:
Cell Phone:	Home Phone:	
Email:	Primary Care Provider:	

Under 18

Guardian name:	Guardian DOB:	Relation to Patient:

Insurance Information

Primary Insurance Carrier:	
Subscriber Name:	Subscriber DOB:
Policy Number:	Group Number:
Secondary Insurance Carrier:	
Subscriber Name:	Subscriber DOB:
Policy Number:	Group Number:

Account Privacy and Medical Records Release

I hereby give consent for Arizona Institute of Dermatology to disclose my medical information to person(s) listed below. I am aware by signing this consent, any and all medical information may be discussed with the person(s) I designate. The consent will remain in effect until otherwise requested in writing. Please list name of person(s) you give permission to release your medical information to:

Name:	Relation:
Name:	Relation:

In Case of Emergency

Name:	Relation:
Phone Number:	

Do you have a Health Care Proxy in the even you are unable to make legal decisions? **Y N**

Designee's Name:_____Designee's Phone Number:_____

Please sign all signature lines below

The above information is true to the best of my knowledge.

_____ _____

Signature of Patient/or Guardian Date

I authorize payments of medical benefits to the provider for services rendered or to be rendered in the future without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary for my insurance to pay the claim. I understand that I am responsible for all charges incurred and that if this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures. Please be advised that if a biopsy is performed, the specimen(s) will be sent to an outside laboratory for either slide preparation and/or pathology readings. This laboratory has its own set of fees and you will receive a bill from their facility. If you have any questions or concerns regarding this bill, please contact the lab directly.

_____ _____

Signature of Patient/or Guardian Date

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program as detailed at length in an attached form. By signing below, I acknowledge that I understand the "HIPAA" policy and may receive a detailed explanation at any time upon request to keep for my records.

_____ _____

Signature of Patient/or Guardian Date