Associates in Dermatology of Traverse City - Patient Information

Patient Last Name: ________________________________First: ____________________________M. I.:______________

Mailing Address: ____

City/State: __________________________________ Zip Code: _____________________

Primary Phone: ____________________________ Cell/Home/Work Date of Birth: _______________________

Alternate Phone: ___________________________ Cell/Home/Work Sex: ☐ Female ☐ Male

Email Address: ____

Responsible Party: ☐ Self (If over 18) ☐ Other _________________________________ Relationship:_______________

Responsible Party Address (If different than Patient): ____

Name of Subscriber: _______________________________________ Relationship: __________________________________

Subscriber Date of Birth: _________________________

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

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Responsible Party Signature Date

HIPAA Release Form

By listing the persons below, I am authorizing any employee of Associates in Dermatology of Traverse City, to release information contained in my patient records to the individuals listed below, only under the conditions listed below:

☐ Do not release any information to anyone.

☐ I authorize information to be released to (PLEASE PRINT NAMES & RELATIONSHIPS):

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Without expressed written revocation this authorization will remain in effect from date of signature.

I acknowledge that I have been offered a copy of Associates in Dermatology of Traverse City's Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

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Signature of Patient/ Patient Representative Date