

**PATIENT REGISTRATION**

Today's Date: _____

Patient Information		
Patients Name: (Last,First,MI)		
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:
Home Ph #	Cell Ph #	Wrk Ph #
Physical Address:		
City/State/Zip		
Mailing Address:		
City/State/Zip		Email:
Occupation:		Preferred Pharmacy:
Emergency/Responsible Party Contact:		
Name:	Relationship:	Phone #:
SSN:	DOB:	
Insurance Information		
Insurance Co. Name		
Policy Holder Name:	Relation to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Policy Holder DOB	Policy Holder SSN:	
Member ID#	Group #	
Please list who we can talk to about your care		
Name:		
Relationship:		
Phone #		
Name:		
Relationship:		
Phone #:		



Patient Financial Policy

We are committed to providing you with quality care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitate to contact our billing department at (985) 868-1810. We require that all patients complete our Patient Financial Policy prior to seeing the physician. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

INSURANCE

- It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will make a copy for our records.
- If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.
- We do not accept Medicaid as a Primary or as a secondary.

CO-PAYS

Co-payments are due at the time of service.

DEDUCTIBLES, CO-INSURANCE and ESTIMATES:

Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of service.

- For surgical and in-office procedures, an estimation of patient responsibility will be provided to you and is to be paid in full PRIOR to services being rendered.
- Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

UN-PAID/OUTSTANDING BALANCES

- We ask that full payment to be made at the time of service unless prior arrangements have been made through the billing office.
- If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due.

You may call our billing office at (985) 868-1810 to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity.

Forms of payment accepted: Cash, Checks, Visa, MasterCard, American Express and Discover.

PATIENT AUTHORIZATION

I consent to treatment, including biopsies, necessary for the care of the below name patient. I understand that I will receive a separate bill from Derm Path Diagnostics of Atlanta (pathologist), or Lab Corporation for each skin specimen processed. (By law Dr. Neal & Dr. Duke is required to send skin specimens to a pathologist for biopsies and surgeries).

Signature of Patient or Legal Guardian: _____ Date: _____



PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

What is “Protected Health Information” or “PHI”?:

Protected health information”, or “PHI” for short, is information that identifies who you are and relates to, your past, present and future physical or mental health or condition, the provision of health care to you, or past, present or future payment for the provision of health care to you. PHI does not include information about you that is publicly available or that is in a summary form that does not identify who you are. If you are an employee of our participating physician’s office, PHI does not include your health information in your personal life.

Purpose of this notice:

in the course of doing business, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practices and how we protect the confidentiality of our PHI. We are obligated to maintain the privacy of your PHI implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this notice about our legal obligations to maintain the privacy of your PHI. We must follow our notice that is currently in effect.

How we protect your PHI We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical, electronic, and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a privacy officer, which has overall responsibility for developing, training, and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use, and disclosure.

The following signature acknowledgement that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Patient Signature or Legal Guardian

Date



Patient Consent for Photo

**IMPORTANT INFORMATION ABOUT THIS DOCUMENT – READ CAREFULLY
BEFORE SIGNING**

TO THE PATIENT: I, undersigned, in the interest of medical education and knowledge, hereby give consent to Duke Neal Medical Dermatology Clinic to make photographs of all or part of my person deemed advisable by my physician, or by the staff of Duke Neal Medical Dermatology Clinic, and I authorize entry into treatment areas of photographer or treatment. Any photograph may be used without my prior examination of the finished product only for the indicated:

For medical records in connection with the delivery of medical care and for diagnostic purposes in my case

I hereby waive my rights to privacy in connection with the consent above given and I hereby release, discharge and agree to hold harmless all the parties to whom this consent is given from any liability whatsoever and agree that this consent and waiver will not be made the basis of a future claim of any kind against the medical staff and personnel of Duke Neal Medical Dermatology Clinic.

THIS CONSENT IS NOT FOR ADVERTISEMENT.

(Print Patient's Name)

Signature of Patient)

(Date

(Signature of patient representative, Date
if required)

(Signature of Witness)



P Mark Neal MD Alexis Duke MD Anne Price MD
12 Professional Dr.
Houma, La 70360
P (985) 868-1810 F (985)876-3670

Authorization to Receive Medical Information

Patient Name (Please Print): _____ **Date of Birth:** _____

Patient Phone: _____

RECEIVE RECORDS FROM:

Phone: _____ **Fax:** _____

Information to be released: (if not clearly defined, the most recent 2 years will be released)

☐ Complete Health Record Date: ____/____/____ (mm/yyyy)

Most Recent: ☐ Lab X-Ray ☐ Office Visit ☐ Pathology Reports ☐ Demographics/Insurance

☐ Other Information (Please specify) _____

Purpose for which disclosure is being made: (please check one of the following) ____ Attorney ____ Insurance
____ Doctor ____ Personal ____ Other _____

EXCLUDE the following information from the records released (please initial): ____ Drug/Alcohol
abuse/Treatment and diagnosis ____ Sexually transmitted disease ____ Mental Illness or psychiatric
diagnosis and treatment ____ HIV/AIDS

MY RIGHTS: I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by the HIPAA regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed with this authorization. There may be a charge for these copies.

This authorization will automatically expire six months from the date signed or until the 3rd party payer claim is secured. I understand that I may revoke this authorization any time except to the extent that action has been taken in relationship thereon. To revoke this authorization, I must submit my request in writing to Duke Neal Medical

Signed: _____ **Date:** _____

(Patient or Legal Guardian)