PATIENT REGISTRATION FORM

PATIENT NAME: _____
Last First Middle Initial

MAILING ADDRESS Street: _____

City: _____ State: _____Zip: _____

DATE OF BIRTH: ___/___/_____ Age: ____ □ Female □ Male SS#: _____

□ Married □ Single □ Widowed □ Divorced RACE: _____ PRIMARY LANGUAGE:_____

DID A DOCTOR REFER YOU TO SEE DR MACKEY? □ YES □ NO

If YES: Doctor's Name: _____ Phone #:_____
First Name Last Name

____ Please initial that you understand that you may see our nurse practitioner at some office visits.

IF PATIENT IS UNDER 19 YEARS OF AGE THIS SECTION MUST BE COMPLETED
The Responsible Party Is The Parent/Legal Guardian Here With The Patient

RESPONSIBLE PARTY NAME: _____
Last First Middle Initial

MAILING ADDRESS: _____
Street City State Zip

DATE OF BIRTH: ____/____/_____ SS#: _____ □ Female □ Male

Is the Responsible Party an existing patient? □ YES □ NO

PRIMARY HEALTH INSURANCE COMPANY: _____

Policy/Contract Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: ___/___/_____

Relationship: _____ Social Security #: _____

SECONDARY HEALTH INSURANCE COMPANY: _____

Policy/Contract Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: ___/___/_____

Relationship: _____ Social Security #: _____

I hereby authorize the release of all medical information necessary to process claims to my insurance carrier and authorize payment directly to Steven L. Mackey. M.D. for services rendered to me or my dependents.

I certify that the above information is correct to the best of my knowledge. I understand that I am financially responsible for payment for all charges for services rendered in my medical treatment regardless of the status of my insurance coverage. If I fail to keep my financial obligations as agreed, I will pay costs of collection, including collection fees and/or attorney fees and waive my exemption under the Constitution and laws of the State of Alabama.

_____ _____
Patient Signature (*If Minor: Responsible Party Signature*) Date

OFFICE FINANCIAL POLICY

PATIENT NAME: _____ Date of Birth: ____/____/_____

We would like to share the following policy with you so that you understand your responsibility regarding the charges of the services rendered to you by this office.

MEDICARE: We are a Medicare participating provider. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for the payment of Deductibles, Copayments; and/or Non-covered or Cosmetic Services. (For non-covered services, you will be asked to sign an Advanced Notice of Liability Form.)
If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, you will be responsible to pay any charges not covered by Medicare. We will bill your insurance company and will refund you if/when these charges are paid by your insurance company.

NON-MEDICARE/CONTRACTED INSURANCE PLANS: If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all covered, medically necessary services rendered. We will bill your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of Annual Deductibles; Copayments; and/or Non-covered or Cosmetic Services. (For non-covered services, you will be asked to sign a Non-Covered Service agreement form.)

NON-MEDICARE/NON-CONTRACTED INSURANCE PLANS: If we do NOT participate (not contracted) with a commercial insurance plan under which you are covered, but we have their information in our data base and we are familiar with their payment history, we will bill the carrier for all medically necessary services rendered. If you are covered by two insurance plans, we will bill your primary first. If they do not pay, we will forward all unpaid charges to you. If your primary pays, we will bill to your secondary one time. If they do not pay, we will bill you all unpaid charges.
If your insurance company is NOT listed in our database and we are not familiar with their payment history, we will collect $125.00 deposit. We will bill your insurance and refund your payment amount once they pay all charges, less any copay and deductible amounts. Please note that if your deductible or copay is more than $125.00, you will receive a statement from us for the additional amount.

REFERRALS: Some insurance policies require a referral from your primary provider. We make every effort to determine if your policy needs a referral and to obtain these referrals for your appointment. However; it is ultimately your responsibility to know your benefits and to ensure that all information is obtained for your appointment. If a referral is needed, but not gotten for your appointment, you will be responsible for payment of all charges incurred.

RETURNED CHECKS AND DELINQUENT ACCOUNTS:
There will be a $30.00 charge on all returned checks.
Agreement to pay for accounts, which become delinquent:
I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such becomes necessary.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):
You agree, in order for us to service your account or to collect a balance you may owe, Alexander City Dermatology and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I have read this Office Financial Policy and agree to all of the above terms. I also consent that Dr. Steven Mackey, Alexander City Dermatology, its employees and/or agents may contact me as described above.

_____ _____
Responsible Party Signature Date

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Our preferred method of contact is by telephone. May we call the following number(s)?

- Home Telephone Number: _____ Yes __ No__
  If you have an answering machine, may we leave personal information? Yes __ No__
  If no, can we leave a call back number? Yes __ No__

- Cell Telephone Number: _____ Yes __ No__
  If you have voice mail, may we leave personal information? Yes __ No__
  If no, can we leave our call back number? Yes __ No__

May we send text message reminders to your cell phone? Yes __ No__

May we mail information to your home address? Yes __ No__

Please provide your email address to access your medical records on our web portal:

Email address: _____

Do you give our office permission to discuss your medical information with anyone? Yes __ No__
If yes, please provide their name(s) and phone number(s). Please note that we cannot discuss anything with anyone if their name is not on this form. This includes phone messages, refills, appointments, billing and insurance information.

1. Name: _____ Relationship: _____

   Home Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

   Home Phone: _____ Cell Phone: _____

3. Name: _____ Relationship: _____

   Home Phone: _____ Cell Phone: _____

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
Responsible Party Signature Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability of Accountability Act of 1996.

The patient understands the following:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

_____

Patient Signature (If Minor: Responsible Party Signature)

_____

Print Patient Name

_____ _____

Relationship to Patient Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice Of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason:_____

Steven L. Mackey, M.D.
FELLOW AMERICAN ACADEMY OF DERMATOLOGY
125 Alison Drive Suite 8
Alexander City, AL 35010
(256) 409-2159
1722 Pine Street Suite 400
Montgomery, AL 36106
(334) 263-1400

Date: _____ Patient: _____

Date of Birth: _____

POSSIBLE NON-COVERED CONSENT

Your signature on the bottom of this form signifies that you understand that services performed in our office may not be covered. Your decision to have a service rendered and your signature indicates an understanding that the service may not be covered and your insurance may not feel it is medically necessary.

You will be responsible for payment in full after the initial visit and fully accept the fact that the charges incurred may be out-of-pocket expenses and may not be covered by your health care plan.

If we are unsure if the procedure is covered, we will submit the charges to your insurance company. If your insurance does not cover this claim, you will be responsible for the charges and we will send a statement to you.

This office will at no time after initial visit submit a claim to your insurance company if the provider has deemed the service to not be medically necessary under the terms of the practice's contract with your carrier.

This consent form is valid for each visit for one year from signature date.

_____
Patient Signature (If Minor: Responsible Party Signature)

_____
Witness (Office Staff)

Updated 01/29/2021