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**___________________________________

Employer______________________________ **Occupation**_________________ **Primary Care/Referring Doctor**___________________

Home Ph.(____)____-_________ **Work Ph.** (____)____-_________**Cell Ph.** (____)____-_________**Marital Status**________

Driver's License_____________________________**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 discuss your information with members of your immediate family or caregiver? YES NO

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?**_________________________

Spouse Information (*if applicable*)

Spouse Name____ DOB______/______/______
First MI Last

SSN ______-_____-_______ **Employer**_______________________________________**Work Ph.** (_____) _____-___________

Parent/Legal Guardian (If patient is insured by parent *or* under the age of 18)

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** (____) ____-__________

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 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
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

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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

BAKERSFIELD DERMATOLOGY & SKIN CANCER MEDICAL GROUP
Phone: 661-327-3756 Fax: 661-327-2332

Medicare Claim Authorization

____
Name of beneficiary (as shown on Medicare card)

____
Complete Medicare Number (Please include all letters and numbers)

Payment Policy

We are participating providers for the Medicare Program. We will accept assignment on all claims. As outlined by Medicare, accepting assignment means it is an agreement by your doctor to be paid directly by Medicare, to accept the amount Medicare approves for the service as payment in full, and not to bill you for any more than the Medicare deductible and coinsurance. Patients are responsible for meeting their annual deductible and for paying their 20% coinsurance. We do file claims with secondary and/or supplemental carriers. However, in the event that the secondary/supplemental carrier does not pay within 90 days, the patient's balance will be billed to the patient.

I, the undersigned, request payment of Authorized Medicare Benefits be made on my behalf to Crowley Medical Corporation, d/b/a Bakersfield Dermatology & Skin Cancer Medical Group for any services furnished me by Jeffrey J. Crowley, M.D., or his employees. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its authorized agent(s) any information needed to determine these benefits or the benefits payable to related services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

____
Signature of Beneficiary

____
Date Signed

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Beneficiary Name:______________________________ Medicare ID #:____________________

Medicare regulations require anyone submitting Medicare claims to determine whether Medicare is the primary payer for those items or services supplied to the beneficiary.

1. **Are you receiving benefits from any of the following programs?**
   Federal Black Lung ☐Yes ☐No
   Government Program/ Research Grant ☐Yes ☐No
   Department of Veteran Affairs ☐Yes ☐No

2. **Is the illness/injury you are being seen for due to an accident?**
   ☐ **No** ☐**Yes- Please answer the following question:**

   What type of accident caused the illness/injury?
   ☐ **Automobile**
   ☐ **Non-automobile**
   ☐ **Work Related**

3. **You are entitled to Medicare based on which of the following:**
   ☐**Age (65 & over)**
   ☐**Disability**
   ☐**End Stage Renal Disease- Please answer the following question:**
   Are you within the 30 month coordination period? ☐**Yes** ☐**No**

4. **Are you currently employed?**
   ☐ **Yes** ☐ **No- Date of retirement: _________________________**

5. **Is your spouse currently employed?**
   ☐ **Yes** ☐ **Not Applicable** ☐ **No-Date of retirement: ___________________**

6. **Do you have group health plan coverage based on your own or a spouse's current employment?**
   ☐ **Yes** ☐ **No**

7. **Does the employer that sponsors your group health plan employ 20 or more employees?**
   ☐ **Yes** ☐ **No** ☐ **I Don't Know**

8. **Are you a member of a Health Maintenance Organization (HMO)?**
   ☐ **No** ☐ **Yes- Please complete the following:**
   Name of Insurance Company or HMO _______________________________________
   Insured's Name and Policy Number ____

9. **Are you currently a patient in a skilled nursing facility; such as a nursing home?**
   ☐ **No** ☐ **Yes- <u>Please provide the staff with the facility information.</u>**

10. **Are you currently enrolled in Hospice?**
    ☐ **No** ☐ **Yes- Date enrolled: _________________________**

My signature below acknowledges I have answered the above questions to the best of my knowledge.

Patient Signature: _______________________________ Date: ________________________

Should you require additional assistance please contact the Medicare Benefits Coordination and Recovery Center at 1.855.798.2627.