



Dermatologic Surgery of Central Virginia

902 East Jefferson Street, Suite 201 Charlottesville, VA 22902

Phone (434) 979-7700 • Fax (434) 979-7715

Patient Information

Chart # _____

| | | | |
|---|--|--|----------|
| <input checked="" type="checkbox"/> Social Security # | <input checked="" type="checkbox"/> Patient Name (Last, First, Middle) | | |
| <input checked="" type="checkbox"/> Street Address | City and State | Zip Code | |
| Home Phone () | Work Phone () | <input checked="" type="checkbox"/> Date of Birth _ / _ / _ | |
| <input checked="" type="checkbox"/> Sex F M | Marital Status M S W D | | |
| Patient's Employer | Employer's Street Address | City and State | Zip Code |
| Occupation | Student Status F = Full time P = Part time | School Name | |

Insurance Information: Please provide a copy of your insurance card(s).

| | | | |
|--|---|---|---|
| <input checked="" type="checkbox"/> Subscriber's Name (Who holds insurance?) | Relationship of Patient to Subscriber (please circle one): Self Spouse Parent Employer | | |
| <input checked="" type="checkbox"/> Subscriber's Social Security # | <input checked="" type="checkbox"/> Subscriber's Street Address | City and State | Zip Code |
| Subscriber's Home Phone () | Subscriber's Work Phone () | <input checked="" type="checkbox"/> Subscriber's Date of Birth / / | <input checked="" type="checkbox"/> Subscriber's Sex F M |
| Subscriber's Employer | Employer's Street Address | City and State | Zip Code |

Emergency Contact Information:

| | | | |
|--------------------------------|-----------------------------|--------------------------|----------|
| In case of emergency, contact: | Street Address | City and State | Zip Code |
| Relationship to Patient | Daytime Phone Number () | Home Phone Number () | |

If this patient is a minor or student:

Please indicate how you would like statements addressed if you do not want them addressed directly to the patient.

COMPLETE REVERSE SIDE

Deemed Consent for Designated Blood Borne Pathogens Consent to Medical Care, and Release of Protected Healthcare Information:

Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility:

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Dermatologic Surgery of Central Virginia is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, Dermatologic Surgery of Central Virginia will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned. Hospital and Dermatologic Surgery of Central Virginia policy protects you as a patient, should you be exposed.

Also...

I voluntarily consent to medical care at Dermatologic Surgery of Central Virginia, which may include examinations, tests, photographs and treatments by doctors and the staff. No promises have been made to me as to the results of treatment or examinations.

I give consent to Dermatologic Surgery of Central Virginia and its staff to use and/or disclose my protected health information for the purpose of treatment, payment, and health care operations (TPO). I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information, and other information used, in whole or in part, to make decisions about me. With my consent, Dermatologic Surgery of Central Virginia may call or mail to my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Dermatologic Surgery of Central Virginia's Notice of Privacy Practices provides me with more information about how the practice and its staff may use and disclose my protected health information for these purposes.

I certify that the information I have reported in regards to my insurance coverage is correct. I hereby authorize the release of pertinent information to my insurance company or HCFA and any other doctors involved with my case. I authorize my insurance benefits to be paid directly to the physician, realizing that I am financially responsible to pay for any non-covered services. If my account becomes assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees.

I acknowledge that I have received or been offered a copy of Dermatologic Surgery of Central Virginia's Notice of Privacy Practices. If I do not sign this consent, Dermatologic Surgery of Central Virginia may decline to provide treatment to me.

| | |
|---|-------|
| PATIENT'S RELATIONSHIP TO SIGNER: (PLEASE CIRCLE) Patient Spouse Parent Child Sibling Other: _____ Patient unable to sign or acknowledge | |
| Signed: | Date: |
| Signed: | Date: |
| Signed: | Date: |
| Signed: | Date: |
| Signed: | Date: |
| Signed: | Date: |