Minor Patient Registration Form

Provider: RJA DCD BJG RJL JEM KJG KAM MAS

IMPORTANT: Any patient under the age of 18 must be accompanied by a parent or legal guardian at their first appointment in order to receive treatment.

Referring Doctor: ____
First and Last Name City, State Phone #

- -

Child's Name: ____
Last First Middle Initial

Date of Birth: ____/____/____ Sex: __ Male __ Female Prefer to be called: ____________

Home Address: ____
Street # Street Name Apt. #

____
City State Zip

Legal Guardian/Parent Name:____
Last First Initial

Guardian Social Security # _________-_____-____________Guardian Date of Birth: ___/___/___

Home Phone (____)____-__________ Work (___)_____-___________ Cell (___)_____-_________

(Please check the box next to the phone number where you would like to receive appointment reminder calls)

Guardian E-Mail address: ____

May we mail or e-mail you special offers? Yes_____ No_____

INSURANCE COVERAGE – <u>PRIMARY</u>

Insurance Co. Name: ____

Name of Policy Holder (Insured): ____

Policy Holder Social Security #: ___________-______-__________________________

Policy Holder Date of Birth: ____/____/____

INSURANCE COVERAGE – <u>SECONDARY</u>

Insurance Co. Name: ____

Name of Policy Holder (Insured): ____

Policy Holder Social Security #: ___________-______-__________________________

Policy Holder Date of Birth: ____/____/____

FINANCIAL POLICY:

<u>It is the policy of this</u> office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductibles, co-payments, and non-covered services.)

____ _____/_____/_____ ____________________________

Signature of parent or legal guardian Date Relationship to patient

(typing full name serves as an electronic signature)

I have received a Notice of Privacy Practices from D.A.W.M. **Initial ________** **Date: _____/_____/___**

(scroll down to the bottom of the page to view a copy of our HIPPA Privacy Act)

<u>How did you hear about us:</u>Radio___Advance___GRPress___InternetWebsite___Family/Friend___Other___

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your answering machine? ____ Yes ____ No

Discuss your child's medical condition with any member of your household? ____ Yes ____ No

If yes, whom: 1) ____ Relationship: ______________

2) ____ Relationship: ______________

____ _____/_____/_____

Signature of Parent/Legal Guardian Date

(typing full name serves as an electronic signature)

Please bring insurance card(s) and photo ID to your appointment.

NOTICE OF HEALTH INFORMATION PRACTICES
DERMATOLOGY ASSOCIATES OF WEST MICHIGAN
NOTICE OF PRIVACY PRACTICES

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

INTRODUCTION

We are committed to treating and using protected health information about you responsibly. This Notice describes how and when we use or disclose that information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH INFORMATION

Your health information serves as a:
* Basis for planning your care and treatment,
* Means of communication among the health professionals who contribute to your care,
* Legal document describing the care you received,
* Means by which you or a third-party payer can verify that services billed were actually provided,
* A tool in educating health professionals,
* A source of data for medical research,
* A source of information for public health officials charged with improving the health of this state and the nation,
* A source of data for our planning and marketing,
* A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:
* Inspect and copy your protected health information,
* Amend your protected health information. But at the same time, the doctor has the right to deny those requests,
* Obtain an accounting of disclosures of your health information.
* Specify the manner in which you receive communication about your records or upcoming appointments,
* Restrict who sees your medical information,
* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Dermatology Associates of West Michigan is required to:
* Maintain the privacy of your health information,
* Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
* Abide by the terms of this notice,
* Notify you if we are unable to agree to a requested restriction,
* Accommodate reasonable requests you may have concerning the manner in which you receive communication about your records or upcoming appointments.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. You will be advised should our information practices change.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

* Information recorded in your records will be used to determine the course of treatment that should work best for you. We may also provide your physician with copies of various reports that should assist him or her in treating you if requested.
* A bill may be sent to you or a third-party payer. The information on or with the bill may include information that identifies you, as well as your balance.
* Members of the medical staff may use information in your health record to asses the care and outcomes in your case and others like it.
* We may contact you by phone to provide appointment reminders.
* We may also call you by name in the waiting room.
* We may contact you by phone or mail to provide you with test results and to provide information that describes or recommends treatment alternatives regarding your care.
* We may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. We require the business associate to appropriately safeguard your information.
* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
* We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Andrea Socia at 616-949-5600.
If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.
The address for OCR is listed below:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201