Kelly Hood, M.D

Welcome to our office!

First Name: _____ Last Name: _____

Date of Birth: _____ Age: ____ Sex: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Social Security number: _____ Marital Status: _____

Responsible Person (if different from above)

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Relationship to Patient: _____

(Please check the box of your preferred contact number and if a messages can be left)

□ Home Phone: _____ □ okay to leave detailed message

□ Cell Phone: _____ □ okay to leave detailed message

□ Work Phone: _____ □ okay to leave detailed message

Email: _____ Would you like to be on our mailing list? Y/N

Emergency Contact: _____ Number: _____

Medications: _____

Allergies: _____

Family History of Skin Cancer? Y/N Have You Had Skin Cancer In The Past? Y/N

Primary Care Physician: _____ Phone: _____

Referred By: _____

Primary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

As a patient, parent of, or as legal guardian of a minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Kelly Hood, M.D. I am financially responsible for non-covered services. I authorize the physician, and release any information necessary to process this request.

Signed: _____ Date: _____

Kelly Hood, M.D.

PATIENT PRIVACY CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the various healthcare providers who may be involved in that treatment directly and providers who may involved in that treatment directly and indirectly.
- Obtain payment from insurance companies and or third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by this office of their "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this office has the right to change its "Notice of Privacy Practices" from time to time, and that I may contact this organization at any time at the address below to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

In addition to the above, I also consent to the following items:

_____ **YES** _____ **NO** Allow messages to be left on my voicemail regarding my health information (i.e. test results, appointment confirmations and appointment follow-ups issues).

_____**YES** _____**NO** Leave message with person who answers your phone if you are not available.

_____**YES** _____**NO** Allow appointment reminders and recall notices to be sent by postcard in the mail.

_____**YES** _____**NO** Allow appointment scheduler to verbally communicate my next appointment and or test information at the checkout desk.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO THE PATIENT: _____

DATE: _____