Brentwood Skin Clinic Registration Form

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Social Security #: _____

Birth Sex: Male Female **Preferred Pronouns**: _____ Marital Status: Married Single Widowed Other

How did you hear about us: Family/Friend Internet Other:_____

Pharmacy(specify): _____ Preferred Contact Method: Email Call Text Portal

Emergency Contact Name: _____ Phone: _____

Relationship to patient: _____

Guarantor/Responsible Party

First Name: _____ Last Name: _____ Middle Initial: ____
DOB: _____ Relationship to Patient: _____
Address: _____
City/state/zip: _____ Phone Number: _____

Financial Responsibility: I (the patient) agree to pay for the services provided AND agree that payment is ultimately MY responsibility and NOT that of my insurance company. I realize that payment of co-pays, deductibles, etc. will be expected at the time of service. I authorize payment for medical services to Dr. Charles Austin Mitchell III, M.D. at Brentwood Skin Clinic, PLLC. I agree to pay all unpaid balances, including but not limited to 1. The principal balance of my bill 2. Collection charges and fees 3. Returned check fee of $50 4. NO SHOW charge of $25

I have received, reviewed, and agree to the Financial Policy **[Initial]**: _____

HIPAA Notice of Privacy Practices: I (the patient) understand that I 1. Have the right to request medical records whenever I would like 2. Have the right to request amendments to my medical records when appropriate 3. Have the right to limit who has access to my personal health information 4. Have the right to choose how healthcare providers communicate with me 5. Have the right to complain about unauthorized disclosure of Private Health Information

I have received, reviewed, and agree to the HIPAA Notice of Privacy Practices **[Initial]**: _____

(If you would like to review the full documents, please request them at the front desk.)

_____ **[Initial]** the staff of Brentwood Skin Clinic may leave a detailed message on voice mail
_____ **[Initial]** The staff of Brentwood Skin Clinic may speak ONLY to the patient
_____ **[Initial]** The staff of Brentwood Skin Clinic may speak to the following person(s):

Name(s): _____ Relationship to Patient: _____

Patient Signature: _____ Today's Date: _____