EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified? _____

Phone ( ) _____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Phone # (evening): (_____)_____

May we leave personal medical information on your answering machine or cell phone?
❑ YES ❑ NO

May we e-mail personal medical information to you? ❑YES ❑ NO

E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____Date _____

Conditions of Registration and Financial Policy

ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **West Hills Dermatology Group & Affiliates**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

_____ _____ ___/___/___
Patient Signature (or Legal Guardian) Printed Name Date

_____ _____ ___/___/___
Witness Signature Printed Name Date