



# CHILDS DERMATOLOGY CLINIC

JAMES N. CHILDS, M.D

MARIA V. CHILDS, M.D.

Date \_\_\_\_\_

## PATIENT REGISTRATION

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
Last First Middle

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_ Referred by \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Address \_\_\_\_\_

Work Telephone Number \_\_\_\_\_ Cell Number \_\_\_\_\_ E-mail \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ Spouse's Work Telephone Number \_\_\_\_\_

Guarantor's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ S S Number \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Guarantor's Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Nearest relative or contact person: Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Telephone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

### INSURANCE INFORMATION - Please provide us with your insurance card(s) to copy for our records.

Insured's Name \_\_\_\_\_ Patient's relationship to insured \_\_\_Self \_\_\_Spouse \_\_\_Child \_\_\_Other

Insured's Date of Birth \_\_\_\_\_

### PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to James N. Childs, M.D.,P.A. I understand that even though I have assigned benefits to be paid directly to James N. Childs, M.D., P.A., I am still responsible for the entire bill.

Signed \_\_\_\_\_ Date \_\_\_\_\_



# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, \_\_\_\_\_ date \_\_\_\_\_ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.



# CHILDS DERMATOLOGY CLINIC

Dermatology and Dermatologic Surgery

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## AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean \_\_\_\_\_.

“Physician” shall be understood to mean Dr. James N. Childs and/or Dr. Maria V. Childs.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties (“ABMS”) board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Academy of Dermatology.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician’s reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Physician

\_\_\_\_\_

Patient/Guardian

Effective from Date of Treatment:

Date of Signature