

Dermatology and Dermatologic Surgery, PC

Dr Larry D Hudson, MD
 1021 W Oakland Ave Suite 102
 Johnson City, TN 37604
 (423)928-9014 Phone
 (423)928-3559 Fax

Patient Information Sheet:

Today's Date:

Patient's Name			M or F	Date of Birth	Age	Social Security Number
Street Address				City	State	Zip
Home Phone	Cell Phone	Work Phone	Patients Employer		Occupation	
Spouse or Parents Name			Employer		Occupation	
Emergency Contact			Relationship		Phone Number	

Health Questions:

1. Have you ever had high blood pressure, rheumatic fever, or other heart trouble? -----
2. Are you currently taking medications? -----
 - a. If so, for what? _____
3. Have you ever had an unusual reaction to any drug or local anesthetic? -----
4. Do you have a personal or family history of asthma or hay fever? -----
5. Have you ever had hepatitis? -----

Yes	No

If there is any other information about your health we should know, please inform the Doctor.

Referred By:	Street Address:	Phone Number:
Pharmacy:	City/State:	Phone Number:

Medical Records Request: A \$20.00 charge is required per request. Payment of cost is required by the provider prior to the records being furnished. (See TN Code 63-2-102) We appreciate a 24 hour notice to complete your request.

- **Payment is expected on the date of service for any insurance that is not filed by the office.**
- **Copayments are expected on the date of service for any insurance that is filed by the office.**
 - **Payment for any cosmetic procedure is due at the time of service.**

Signature of patient or responsible party: _____

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>																																																																																																																																																					
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)																																																																																																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																											
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																																																																																																																																											
CITY					STATE					CITY					STATE																																																																																																																																						
ZIP CODE					TELEPHONE (Include Area Code) ()					ZIP CODE					TELEPHONE (Include Area Code) ()																																																																																																																																						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																																																																	
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE																																																																																																																																											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																																											
SIGNED <input checked="" type="checkbox"/>										DATE										SIGNED <input checked="" type="checkbox"/>																																																																																																																																	
14. DATE OF CURRENT: MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																	
															17a. NPI																																																																																																																																						
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24e by Line)										23. PRIOR AUTHORIZATION NUMBER																																																																																																																																											
1. _____										3. _____																																																																																																																																											
2. _____										4. _____																																																																																																																																											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #																																																											
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25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$																																																																																									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																																																																																																																	
SIGNED										DATE										a.										b.										a.										b.																																																																																																			

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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With my consent, Dermatology & Dermatologic Surgery, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology & Dermatologic Surgery's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology & Dermatologic Surgery reserves the right to revise its Notice of Privacy practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the address above.

With my consent, Dermatology & Dermatologic Surgery may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology & Dermatologic Surgery may send mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dermatology & Dermatologic Surgery may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dermatology & Dermatologic Surgery restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to, Dermatology & Dermatologic Surgery's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology & Dermatologic Surgery may decline to provide treatment to me.

Signature of Patient/Guardian

Date

Patient's Name (print)

Guardian's Name (print)

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Authorization to Release Information

I, _____, authorize Larry D Hudson, MD to release information regarding my treatment to the following person/persons:

Family Member's Name Relationship

Doctor's Office Phone Number

Facility Phone Number

Release these Records:

Initials:

1) Only records generated by this facility	
2) Only some portion of records maintained at facility(specify dates of treatment) Dates of Tx:	
3) All medical records at this facility	

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release information specified to the individual named on this request with the exception of: Initials:

1) Substance abuse, if any	
2) AIDS/HIV, if any	
3) Psychological or psychiatric conditions	
4) Other(please specify):	

Patient Name (print) Date of Birth Social Security #

Patient/Guardian Signature

Guardian Relationship

Date

Guardian Name (print)

Expiration or revocation of authorization- I understand that I revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date below. Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original.