



Patient Name: _____ Age: _____

“Notice of Privacy Practices” will be provided at check in for your review. My signature below acknowledges that I have read and understand the “Notice of Privacy Practices”.

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Calvert Dermatology
P.O. Box 1540
Prince Frederick, MD 20678
(410) 535-4561

Effective Date: This notice is effective on or after July 1, 2007.

By signing this document I acknowledge receipt of the Calvert Dermatology Privacy Notice.

Patient Signature

Date

PLEASE ANSWER ALL THE QUESTIONS ON THE BUBBLESHEET BY FILLING IN THE CIRCLES COMPLETELY. (YOU WILL BE GIVEN THIS BUBBLESHEET UPON CHECK IN)

For example: Will the Redskins win the Super Bowl next year? No **YES**

Reason for visit: _____

Please List Your Current Medications:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you have medication allergies? No YES: _____

Please list any MAJOR surgeries: _____

Women:	Are you pregnant or planning pregnancy?	<input type="radio"/> No	<input type="radio"/> YES
	Are you currently nursing?	<input type="radio"/> No	<input type="radio"/> YES

In order for us to send a letter to your doctor regarding today’s visit, we need a note from them requesting this consultation.

-Are you being sent by another doctor for consultation? No YES

-Who is the physician that has requested this consultation in writing? _____



Patient Name: _____
Mailing Address: _____ City _____ State _____
Zip _____
Date of Birth: _____ Gender: _____ SS#: _____
Phone Numbers*: Home: _____ Work: _____ Cell: _____
Employer Name: _____
Primary Care Physician Name: _____ Location: _____
Referring Physician Name: _____ Location: _____
Preferred Pharmacy: _____ Location: _____
***note: we will fax your prescriptions to this pharmacy**
Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance: _____ Insured's Name: _____
If NOT the patient, Insured's Date of Birth: _____ Insured's SS#: _____
Member ID Number _____ Group Number _____

Secondary Insurance: _____ Insured's Name: _____
If NOT the patient, Insured's Date of Birth: _____ Insured's SS#: _____
Member ID Number _____ Group Number _____

I certify that the above information is correct:

Signature of Patient or Legal Guardian (SEAL) Date

PATIENT RESPONSIBILITY

1. I understand and agree that the patient (or legal representative) is always financially responsible to Calvert Dermatology for payment of his/her bill. Third party coverage does not waive this responsibility from the patient or guarantor. Calvert Dermatology and its contracted providers assume no liability for the failure of an insurance carrier or other third party to pay part or all of the patient's balance.
2. I understand and agree that should my account be forwarded to a collection agency or an attorney, I will pay a collection fee of 35% and a processing fee of \$25. If filing a lawsuit is ultimately necessary, the collection fee shall be 50%.
3. As of October 1, 2008, the rates for medical record copying per the Health General Article 4-304 (c)(3) are as follows:
 - Preparation fee of \$20.00, plus
 - A fee of \$0.73 per page copied, plus
 - The actual cost of shipping and handing.
4. I certify that I have read this form and that I understand its contents.

Signature of Patient or Legal Guardian (SEAL) Date

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby authorize examination and treatment deemed necessary by my physician. I, the undersigned, authorize and assign payment of medical benefits to which I am entitled to my physicians for any services furnished to me. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. I also authorize any holder of medical information about me to release to Calvert Dermatology and its agents any information needed to determine these benefits or benefits payable for related services.

Signature of Patient or Legal Guardian (SEAL) Date

*Please inform receptionist of any phone number(s) where we may not leave a message.