SODERSTROM DERMATOLOGY CENTER, SC, PEORIA AMBULATORY SURGERY CENTER & HARLAN DERMATOLOGY
PATIENT INFORMATION RECORD

(please print)

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.

Patient Name: _____ Birthdate: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone: *Home* ( ) _____ - _____ *Work* ( ) _____ - _____ *Mobile* ( ) _____ - _____

Social Security #: _____ Email Address: _____

☐ *I do not wish to receive educational information via email, information about upcoming seminars, special events and valuable offers from Soderstrom Skin Institute*

Preferred Contact Method for appointment reminders: ☐ Home Phone ☐ Work ☐ Mobile ☐ Text

Patient's Sex: ☐M ☐F Marital Status: ☐Married ☐Single ☐Other Spouse Name: _____

Emergency Contact: _____ Phone: ( ) _____ - _____

Relationship: _____

Patient Occupation/Student: _____ ☐ Full time ☐ Part time ☐ Retired

Race
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiin or Other Pacific Islander
☐ White
☐ Decline to Provide

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other
☐ Decline to Provide

Primary Language
☐ English
☐ Spanish
☐ Other
☐ Decline to Provide

Referring Physician/PA-C/Nurse Practitioner: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ Address: _____

The following individuals have my permission to access my Protected Health Information *(Spouse, Mother, Father, Life Partner etc.):*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have fully completed this form and certify that I am the patient, or adult authorized general agent of this patient, authorized to furnish the information requested and the information is true. Further, I authorize release of any medical information requested by my insurance company or by referring physician. I request that payment of insurance benefits be made directly to Soderstrom Dermatology Center, S.C. (SDC) and/or Peoria Ambulatory Surgery Center (PASC) and/or Harlan Dermatology (HD) and/or Associated Anesthesiologist, S.C. I am fully financially responsible for all cosmetic procedures, or any procedures not covered by my insurance company.

I understand my insurance coverage is a contract between myself and my Insurance company and I agree to accept financial responsibility for payment of charges incurred. Billing for pathology may be done at the time the lesion(s) was/is removed or later at the time the specimen is read under the microscope. If a second consultation for pathology is required, or special stains are needed, there may be an additional bill from an outside pathologist or lab. In addition, I understand that SDC does not accept insurance company "usual and customary payments" as payment in full. I also agree if I fail to make payment in full (in a timely manner) or if I fail to make a reasonable payment arrangement and my account becomes past due, I shall be liable for and I agree to pay, all collection agency fees and reasonable attorney's fees and court cost.

I acknowledge that I have reviewed SDC's, PASC's and HD's Notice of Privacy Practices. I understand that SDC can change these privacy practices. I understand that this consent is valid until revoked by me. I understand that I may revoke this consent at any time by giving written notice to SDC. I understand that I will not be able to revoke this consent in cases where SDC has already relied on it to use or disclose my health information. I understand that any Revised Notice will be posted in SDC's office and on its website.

Furthermore, I acknowledge that if I provide my health information electronically to SDC, PASC and/or HD's, I understand that it may not be secure. I understand that I always have the option to decline to have clinical discussions via electronic means. SDC, PASC and HD's will strive to take reasonable safeguards and precautions while communicating via text messaging and email and ensure communications are in compliance with applicable federal law. I am aware that text messaging and email communications carry risk of breach of privacy and/or confidentiality, difficulty in validating the identity of the parties, and possible delays in response.

DATE ____/____/____ **PATIENT/RESPONSIBLE PARTY SIGNATURE:** _____

SODERSTROM DERMATOLOGY CENTER, S.C.
d.b.a. PEORIA AMBULATORY SURGERY CENTER
d.b.a. SKIN DIMENSIONS ("SDC" or the "Practice")
d.b.a. HARLAN DERMATOLOGY

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

As a patient, you have the right to request limitations and restrictions on the use and disclosure of your Protected Health Information. The Practice is not required to agree to any restrictions in the use and disclosure of Protected Health Information, unless the request is for payment or health care operations purposes when the Practice has been paid out of pocket and in full consistent with Section 13405 of the HITECH Act and the Practice has been notified of the request for restriction by the patient, and the disclosure is not required by law. The Practice may terminate its agreement to a restriction, except with restrictions required by law. Information created or received prior to removing the restriction may be released by agreement.

To request to inspect and copy Protected Health Information, you must submit your request in writing on this form to SDC's Privacy Officer:

Christina M. Peugh, Privacy Officer
4909 N. Glen Park Place, Peoria, IL 61614

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Address: _____
Street

_____
Apartment Number

_____
City, State, Zip Code

The health information to be used or disclosed is limited to the following: *(you may note dates, procedures or use other description)*

_____

_____

_____

Who is approved for access to PHI:

- ❑ Spouse _____
- ❑ Parent _____
- ❑ Other _____

Signature of Patient:_____Date: _____

Printed Name:_____

Signature of Legal Guardian: _____Date: _____

Printed Name:_____