

Kay Bishop, M.D.
Cameron French, PA-C

DERMATOLOGY OF EASTERN IDAHO

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PATIENT INFORMATION SHEET

Patient: Name _____ Today's Date _____

Gender: Male Female Marital Status _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address (if different than mailing address) _____

Cell Phone Number _____ Home Phone Number _____

Place of Employment _____ Work Phone _____

Name of Spouse _____ Reason for Visit _____ Date of Onset _____

Social Security Number _____ Patient was referred by: _____

Person Responsible for Payment: Name _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address (if different than mailing address) _____

Cell Phone Number _____ Home Phone Number _____

Place of Employment _____ Work Phone Number _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Relationship to Patient _____

Emergency Contact (please list someone not living with you): Relationship _____

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Physical Address (if different than mailing address) _____

Insurance information

Copies of Insurance Cards and Photo ID will be taped here

Insurance Company _____ I.D. Number _____

Group Number _____ Address _____

Name of Insurance Policy Holder _____ Date of Birth _____

Social Security Number _____

Secondary Insurance Company _____ I.D. Number _____

Group Number _____ Address _____

Name of Insurance Policy Holder _____ Date of Birth _____

Social Security Number _____

Information Release:

I hereby authorize Kay Bishop, M.D. to release any information acquired in the course of my examination or treatment to the insurance carriers. I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to Kay Bishop, M.D.

Assignment of Insurance Benefits:

I hereby authorize payment of benefits directly to Kay Bishop, M.D. I understand I am financially responsible for the charges not covered by my insurance company.

Signature _____ (relationship to patient)

Medigap Patient’s Assignment Authorization

I request that payment of authorized Medigap benefits be made on my behalf to Kay Bishop, M.D., for any services furnished to me by Kay Bishop, M.D. This authorization applies to all occasions of services until it is revoked.

Patient’s Signature _____ Date _____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthy care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthy care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices, should it become necessary within the law.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Consent signed by: _____
Printed Name—Patient or Representative

_____/_____/_____
Signature Date

Relationship to Patient (if other than Patient)