LIMMER DERMATOLOGY
Your Skin. Our Specialty.

4630 N. Loop 1604 W., Ste. 316
San Antonio, TX 78249
Phone: 210-496-9929

Patient: _____
First Name Initial Last

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Other

SSN: _____ Birth Date: _____ Age: _____

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

Home Phone: _____ Cell Phone: _____ Preferred: ☐ Cell ☐ Home

Emergency Contact: _____ Phone: _____

Responsible Party: _____

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

Home Phone: _____ Cell Phone: _____ Preferred: ☐ Cell ☐ Home

Primary Insurance: _____
Name Policy # Group #

Secondary Insurance: _____
Name Policy # Group #

DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION

In general, the HIPPAA privacy act gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.
I wish to be contacted in the following manner (*check all that apply*):

Telephone
Leave Detailed Message at home Y ☐ N ☐
Leave Call Back Number at home Y ☐ N ☐
Leave Detailed message at work Y ☐ N ☐
Leave Detailed Message on cell phone Y ☐ N ☐
☐ **No Restriction Requested**

Written Communication
Ok to mail my home Y ☐ N ☐
Ok to fax to this number Y ☐ N ☐
_____

Authorized PHI Recipients
Spouse Y ☐ N ☐ Name: _____
Parent Y ☐ N ☐ Name: _____
Child Y ☐ N ☐ Name: _____
Other (relationship) Name: _____

HIPAA ACKNOWLEDGEMENT

We ask that you sign your name in the space provided to indicate that you have read the HIPAA NOTICE posted in our office as well as the OFFICE POLICY GUIDELINES provided for your review. You may request a copy of the HIPAA NOTICE at our front desk if you desire. Your signature indicates your agreement to follow the HIPAA policies established here.

(X) _____ _____ _____
Patient / Guardian (if minor) Relationship Date

PATIENT ACKNOWLEDGEMENT

I, the undersigned, certify that all information listed above is current and correct. I or my dependent have insurance coverage as indicated above and assign directly to LIMMER DERMATOLOGY all insurance benefits. I understand that I am financially liable for all charges whether or not paid by Insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

(X) _____ _____ _____
Patient / Guardian (if minor) Relationship Date