MILL VALLEY DERMATOLOGY
Haydee Knott, MD
655 Redwood Hwy, Frontage Rd Suite #100
Mill Valley, CA 94941
PH: 415-634-8411 F: 844-880-4434
www.millvalleydermatology.com

DATE _____/_____/_____

NAME: LAST_____ FIRST_____ MIDDLE INITIAL_____

PREFERRED NAME (IF DIFFERENT FROM ABOVE)_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL_____ WORK_____ EXT_____

PERMISSION TO LEAVE MESSAGE: **HOME** ☐ YES ☐ NO **CELL** ☐ YES ☐ NO **BEST NUMBER TO REACH YOU:** _____

EMAIL FOR PATIENT PORTAL ACCESS: _____+_____

PRIMARY CARE DOCTOR_____ PHONE_____

REFERRING PHYSICIAN_____ _PHONE_____

DATE OF BIRTH _____/_____/_____ **SEX** ☐ F ☐ M **SOCIAL SECURITY NUMBER** _____ /_____ /_____

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ PARTNER ☐ WIDOWED ☐ MARRIED (spouse name)

EMPLOYER NAME _____ ADDRESS_____

EMPLOYMENT STATUS ☐ FULL TIME ☐ NOT EMPLOYED ☐ RETIRED ☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY

ETHNICITY_____ PRIMARY LANGUAGE_____

RESPONSIBLE PARTY IF MINOR ☐ PARENT ☐ GUARANTOR RELATIONSHIP (other than parent)

NAME _____ ADDRESS _____

CITY_____ STATE_____ ZIP_____HOME PHONE _____

PRIMARY INSURANCE CARRIER_____ INSURANCE ID/GROUP #_____

Are you the primary insured? ☐Yes ☐ No
(Skip if "Yes") PRIMARY INSURED NAME_____Date of Birth_____

SECONDARY INSURANCE CARRIER_____INSURANCE ID/GROUP#_____

EMERGENCY CONTACT NAME, LAST_____ FIRST _____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE NUMBER (_____) _____ -_____ WORK / CELL PHONE NUMBER (_____) _____-_____ EXT._____

PHARMACY NAME_____ **LOCATION**_____

PHONE (_____) _____-_____ FAX (_____) _____ -_____

_____ _____

PATIENT SIGNATURE IF PATIENT IS A MINOR, PARENTS SIGN HERE FOR PERMISSION FOR TREATMENT

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655 Redwood Hwy Frontage Rd, Ste 100
Mill Valley, CA 94941
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RELEASE/ASSIGNMENT/ACKNOWLEDGEMENT

I consent to medical examination, treatment, and diagnostic studies advised by the physician. I authorize insurance benefits be paid directly to the practice. Haydee Knott, MD-Mill Valley Dermatology. will offer what they feel, in their medical opinion, is medically necessary for my healthcare.

I HEREBY AUTHORIZE MILL VALLEY DERMATOLOGY. TO RELEASE PERTINENT INFORMATION REGARDING MY CARE TO OTHER PHYSICIANS AND/OR INSURANCE COMPANIES HOLDING POLICIES ON ME.

I authorize my insurance company to directly remit payment to Mill Valley Dermatology for medical and surgical services provided.

I understand some services advised by my doctor may or may not be covered by insurance. **I understand that I am financially responsible for any outstanding balance and my credit card will be billed via the Easy Pay Form.** Should my credit card be declined or cancelled, I understand accounts 120 days past due will be transferred to a third party collections agency and that I will be responsible for any and all fees associated with this transfer.

I UNDERSTAND THAT BY NOT PROVIDING THE OFFICE WITH ALL INFORMATION REQUESTED AND/OR COPIES OF MY INSURANCE CARD(S) AT TIME OF SERVICE, THIS COULD CAUSE A DELAY IN THE PROCESSING OF MY CLAIM AND I COULD CONSEQUENTLY RECEIVE A BILL FOR THESE SERVICES.

I understand that "No Show" appointments and *repeated* less than 24hr cancellations will result in fees of up to $50.00 charged to my account.

My signature below indicates my acceptance/understanding of the above statements.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Signature of patient: _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

Our Commitment to your Privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. *Communications:* You can request that your physician's office communicate with you about your health and related issues in a specified manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we are bound by our agreement except when otherwise required by the law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decision about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing to Haydee Knott, MD, 655 Redwood Hwy Frontage Rd, Suite 100, Mill Valley, CA 94941.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Haydee Knott, MD, 655 Redwood Hwy Frontage Rd, Suite 100, Mill Valley, CA 94941. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact our office 415-634-8411. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. If a disclosure is made for any reason other than treatment, payment or operation, you have the right to an account of those disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Office at 415-634-8411. We reserve the right to revise this notice at any time without notification.

I hereby acknowledge that I have been presented with a copy of Haydee Knott's M.D. Notice of Privacy Practices.

_____ _____

Signature Date

Patient's Name: (please print) _____

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Cancellation Policy

I take pride in making a conscious effort to accommodate my patients' schedules and that each patient is seen in a timely fashion. I believe that your time is as valuable as my own.

If you are unable to keep your appointment, please give a 24 hours notice so that someone else needing my services may be seen at that time. We will be happy to re-schedule your appointment for a future date.

I understand that failure to cancel or re-schedule an appointment without a 24 hour notice will result in a No Show appointment charge of $50.00.

Patient Signature _____ Date _____

Printed Name _____