Privacy Notice Acknowledgement

Patient Name: _____ **Date of Birth :** _____

Preferred Name: _____

Social Security Number: _____ (REQUIRED)

Occupation: _____ **Employer:** _____

Primary doctor: _____ ❑ I do not currently have a PCP

I grant MOD Dermatology permission to contact the following person(s) regarding my health care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I prefer to be contacted by (check all that apply):

☐ Cell phone: _____

☐ Home phone: _____

☐ Work phone: _____

If I am unavailable, I give MOD Dermatology permission to leave a voicemail regarding (check all that apply):

☐ **ANY** of the following information:

☐ Claims and billing information

☐ Appointment Date and Time

☐ Prescription/Pharmacy Information

☐ Normal Test Results

☐ Please DO NOT leave a message under any circumstances

☐ I also give permission to MOD Dermatology to text me the above information

How did you hear about our clinic? _____

I have received MOD Dermatology's Notice of Privacy Practices. A copy has been offered to me.

Signature of Patient or Guarantor: _____ Date: _____