

PATRICK M. HATFIELD, M.D., P.A.

DERMATOLOGY

299 EAGLE MOUNTAIN BLVD, PO BOX 2276, BATESVILLE, AR 72503

PHONE: (870) 698-9100 FAX: (870) 698-0161

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: ____/____/____ SEX: M / F EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

HOME AND BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOBBIES AND INTERESTS: _____ SOCIAL SECURITY NUMBER: _____

DO YOU HAVE AN ADVANCE DIRECTIVE/LIVING WILL: YES OR NO

IF YES, WOULD YOU LIKE TO PROVIDE OUR OFFICE WITH A COPY? YES OR NO

PRIMARY CARE PROVIDER / REFERRAL / PHARMACY

WHO IS YOUR PRIMARY CARE PROVIDER? _____

REFERRED BY: _____ WHAT PHARMACY DO YOU USE? _____

EMPLOYMENT INFORMATION

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

WORK PHONE: _____ OCCUPATION _____

SPOUSE/EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE: _____ WORK PHONE (IF APPLICABLE): _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

ADDRESS: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

MEDICAL INFORMATION

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

REASON FOR TODAY'S VISIT: _____

DURATION OF CONDITION: _____ PREVIOUS TREATMENTS: _____

OTHER MEDICAL CONDITIONS: _____

SURGERIES: _____

HAVE YOU FALLEN IN THE LAST YEAR? Y / N

IF YES, DID YOU INJURE YOURSELF? Y / N

SIGNATURE: _____ DATE: _____

HIPAA PRIVACY AUTHORIZATION FORM

PATRICK M. HATFIELD, M.D., P.A.

DERMATOLOGY

299 EAGLE MOUNTAIN BLVD, PO BOX 2276, BATESVILLE, AR 72503

PHONE: (870) 698-9100 FAX: (870) 698-0161

Authorization for Use and Disclosure of Protected Health Information (PHI)

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE: _____ ADDRESS: _____

HOW WE MAY DISCLOSE YOUR INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we may use or disclose your health information for:

- Treatment – coordination or management of your care (e.g., sharing with labs, referring physicians, pharmacies)
- Payment – billing and payment activities (e.g., submitting claims, verifying insurance)
- Healthcare Operations – quality improvement, staff training, or audits

We will obtain your authorization for any other use or disclosure not described above (such as for education or marketing).

YOUR RIGHTS

- Access and request a copy of your medical records
- Request corrections to your records
- Receive an accounting of disclosures
- Request restrictions on certain uses or disclosures
- Receive communications by alternative means or at alternative locations
- Revoke this authorization in writing at any time

Authorization for Disclosure of Protected Health Information

This authorization allows Patrick M. Hatfield, M.D., P.A. – Dermatology to release or obtain information from/to the individuals or organizations listed below:

_____ Relationship: _____
 _____ Relationship: _____
 _____ Relationship: _____
 _____ Relationship: _____

LIMITATIONS

This authorization includes all medical and billing records related to my care, unless I specify otherwise below. Limitations, if any: _____

EXPIRATION

This authorization will remain in effect until revoked in writing by the patient or their legal representative. I understand that signing this authorization is voluntary and not a condition of receiving treatment or payment. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy regulations. Written revocations should be sent to: Privacy Officer, Patrick M. Hatfield, M.D., P.A. – Dermatology, 299 Eagle Mountain Blvd, PO Box 2276, Batesville, AR 72503

REVOCATION

I understand that I may revoke this authorization at any time by submitting a written request to the Privacy Officer at Patrick M. Hatfield, M.D., P.A. – Dermatology. Revocation will not apply to information already released under this authorization.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Legal Representative (if applicable): _____

Relationship to Patient: _____

PATIENT FINANCIAL AGREEMENT AND OFFICE POLICIES

PATRICK M HATFIELD, M.D., P.A.

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AUTHORIZATION AND ACKNOWLEDGEMENT

I authorize Patrick M. Hatfield, M.D., P.A., Dermatology, to provide medical evaluation and treatment as deemed necessary.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges whether paid by insurance or not.

Payment for all deductibles, co-payments, and uncovered services are due at the time of service. Self-pay and cosmetic services must be paid in full at the time of service. We accept cash, check, credit cards, and CareCredit. Please provide current insurance card(s) and contact information for each visit.

I authorize the release of medical information necessary to process insurance claims and secure payment of benefits.

I authorize direct payment of insurance benefits to Patrick M. Hatfield, M.D., P.A., Dermatology.

I understand that this consent will remain valid until revoked in writing and that a photocopy shall be as valid as the original.

Three statements will be sent:

1. First - courtesy reminder
2. Second – past-due notice
3. Third – Final Notice - The account may be sent to collection, and future appointments may not be scheduled until the balance is resolved.

CANCELLATIONS, LATE ARRIVALS & NO-SHOWS

Please arrive about 15 minutes early so we can update your information before your visit. Complete any required forms ahead of time to help us stay on schedule and make your check-in quick and easy. If you need to change or cancel an appointment, please let us know at least 24 hours in advance, if possible, so we can offer that time to another patient. No-shows or same-day cancellations may result in a \$50 fee. After two missed appointments, we may need to limit future scheduling.

INSURANCE POLICY

Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file claims for you, but you are responsible for co-pays, deductibles, and non-covered services. Our practice contracts independently with insurance carriers and cannot guarantee network participation with other facilities. UAMS performs all histology (biopsy/excision) services. The pathology bill may be billed separately by the pathology laboratory.

MEDICARE POLICY

We accept Medicare assignment and will adjust fees to Medicare approved amounts. We will file one secondary claim; additional secondaries must be filed by the patient. For services Medicare may not cover, you will be asked to sign an ABN (Advance Beneficiary Notice) and pay at the time of service.

MINOR POLICY

Patients under 18 must be accompanied by a parent or legal guardian. If unavailable, the appointment will need to be rescheduled.

PHOTOGRAPHY AND DOCUMENTATION CONSENT

I consent to the use of medical photography and secure digital documentation tools to support accurate medical recordkeeping and clinical care. Photography is only used during surgical procedures and strictly for referrals and insurance purposes. These tools may assist the provider in preparing an accurate summary of my visit. Any recordings or transcripts created during this process are temporary, used only to complete the medical note, and not stored once documentation is finalized. All information remains confidential within my medical record, will be handled with HIPAA regulations and is never shared or used for non-medical purposes without my written consent. Refusing consent will not affect my care and I may withdraw consent at any time by notifying the office in writing.

PHARMACY CONSENT

I authorize the provider to access my prescription history (including over-the-counter medications) to support safe and accurate medication management.

SKIN CANCER FOLLOW-UP

If diagnosed with skin cancer, I understand it is my responsibility to schedule and maintain follow-up care with Dr. Hatfield or another dermatology provider.

PRIVACY AND COMMUNICATION POLICY

All patient information is handled in compliance with HIPAA privacy regulations. For your protection, please use our secure patient portal or call the office for any medical or scheduling questions. Email or text should be reserved for general inquiries only.

USUAL AND CUSTOMARY RATES

We charge usual and customary rates for our area. You are responsible for payment regardless of any insurance company's determination of coverage or fee schedule.

I have read, understand, and agree to these policies and procedures.

PATIENT/GUARDIAN SIGNATURE

DATE

NOTICE OF PRIVACY PRACTICES

PATRICK M. HATFIELD, M.D., P.A.

DERMATOLOGY

299 EAGLE MOUNTAIN BLVD, PO BOX 2276, BATESVILLE, AR 72503

PHONE: (870) 698-9100 FAX: (870) 698-0161

EFFECTIVE DATE: JANUARY 1, 2025

This Notice describes how your medical information may be used and disclosed, and how you can access that information. Please read it carefully.

OUR DUTIES

We are required by law to:

- Maintain the privacy and security of your protected health information (PHI).
- Provide you with this Notice of our legal duties and privacy practices.
- Notify you promptly if a breach occurs that may have compromised your information.
- Follow the terms of the Notice currently in effect.
- Not retaliate if you exercise your rights.

HOW WE MAY DISCLOSE YOUR INFORMATION

We may use or disclose your PHI for the following purposes without your written authorization:

Treatment – To provide, coordinate, or manage your care (for example, sending biopsy results to your referring physician).

Payment – To bill and obtain payment for services rendered.

Healthcare Operations – For practice management, quality assessment, staff training, and compliance purposes.

We may also disclose information:

- To comply with public health reporting (disease prevention, FDA oversight).
- For health oversight or law enforcement if required by law.
- To avert a serious threat to health or safety.
- For workers' compensation or other legally required programs.
- To family members or others involved in your care when appropriate.

Any other disclosure requires your written authorization, which you may revoke at any time in writing.

YOUR RIGHTS

You have the right to:

1. Inspect and obtain a copy of your medical record, with limited exceptions.
2. Request an amendment if you believe your record is incorrect or incomplete.
3. Request restrictions on how we use or disclose your information (we may not be able to agree to all requests).
4. Request confidential communications (for example, by alternate address or phone number).
5. Receive an accounting of disclosures made in the past six years that were not for treatment, payment, or operations.
6. Receive a copy of this Notice, even if you agreed to an electronic version.
7. Be notified of a breach of unsecured PHI that may affect you.

YOUR CHOICES

For certain information, you can tell us your preferences about what we share. These include:

- Sharing information with family or friends involved in your care.
- Sharing information for public relations purposes (such as photos or testimonials).
- Sharing information for fundraising or marketing activities.

If you give permission, you can change your mind at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. Updated versions will be posted in our office and on our website. The new notice will apply to all PHI we maintain, including information created before the change.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us **or** with the U.S. Department of Health and Human Services, Office for Civil Rights.

We will not retaliate against you for filing a complaint.

CONTACT FOR COMPLAINTS OR QUESTIONS:

Privacy Officer: Patrick M. Hatfield, M.D., P.A.
299 Eagle Mountain Blvd. / PO Box 2276 Batesville, AR 72501
Phone: (870)698-9100

HHS OFFICE FOR CIVIL RIGHTS:

U.S. Department of Health and Human Services
200 Independence Ave SW, Room 509F
Washington, DC 20201
Phone: 1-800-368-1019
Website: <https://www.hhs.gov/ocr/privacy/hipaa/complaints/>

STATE LAW

Where **Arkansas law** provides stricter privacy protection than federal law, we will comply with the stricter standard.

ACKNOWLEDGEMENT

By signing this form, you acknowledge that you have received and reviewed this Notice of Privacy Practices.

SIGNATURE

DATE