Consent Form

Patient Label

dermatology CONSULTANTS

The Health Insurance Portability and Accountability Act (HIPAA) requires Dermatology Consultants to obtain your authorization to allow communications regarding your protected health information. This authorization allows Dermatology Consultants to discuss your health care with a spouse, child, friend, or other family member that you designate. It also allows Dermatology Consultants to leave recorded messages at your home, work, or on your cell phone related to your medical care and treatment, payment, appointment status, or follow-up. It also allows Dermatology Consultants to send electronic messages via the patient portal related to your medical care and treatment, payment, appointment status, or follow-up.

List phone number(s) in order of preference for receiving appointment reminder and/or patient care calls:

Please circle type:		*Please circle patient care messaging preferences below:*				
1. Home / Cell / Work	_____	no message	/	message to call	/	detailed message
2. Home / Cell / Work	_____	no message	/	message to call	/	detailed message
3. Other	_____	no message	/	message to call	/	detailed message

☐ Yes, please contact me for news and events in our practice. Email:_____

☐ Yes, I want to participate in the patient portal. Email:_____

☐ No, I do not want to provide my email address.

(We will not share your email address.)

☐ Yes, you may upload my prescription information from outside providers.

This authorization allows Dermatology Consultants to discuss all aspects of my protected health information with the individual listed below:

Name:_____ Relationship:_____ Phone number_____

Please initial each line item and sign below.

Initial:_____ **Records Release:** I authorize the release of my health information by Dermatology Consultants, P.A. for the purposes of my current treatment, including release of information to my referring or primary care provider and other health care providers participating in my current treatment, or as otherwise necessary for Dermatology Consultants, P.A. to provide treatment to me. I authorize the release of medical information (including billing information) as necessary for payment purposes, including release by Dermatology Consultants, P.A. to my insurance company, the responsible party named above, and any other person or entity responsible for payment for my medical treatment. I authorize the release of my health information to business associates of Dermatology Consultants, P.A. as necessary for the purposes of Dermatology Consultants, P.A.'s health care operations.

Initial:_____ **Assignment of Benefits:** I authorize payment of medical benefits to Dermatology Consultants, P.A. for services rendered to myself and/ or dependent. **Patients without Insurance:** If you do not have insurance, or your insurance company does not cover your services, we require that you make a down payment of $100.00. This is not payment in full, and you will be responsible for all charges accrued on your account. Your $100.00 down payment will be applied as a payment on your account and you will be billed for the remaining amount due. A down payment of $250 is required for MOH'S Surgery

For Medicare recipients only:

Initial:_____ **Medicare Authorization:** I request that payment of authorized Medicare benefits be made on my behalf to Dermatology Consultants, P.A. for any services furnished me by that physician / clinic / supervisor. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Initial:_____ **MEDIGAP:** I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for related services.

I understand I may refuse to sign this authorization and realize this may result in a delay of treatment and/or have potential adverse health consequences. This authorization will expire in one year from the date signed; however, I may change or revoke it at any time.

_____ _____ _____

Signature of Patient or Legal Representative | Print Name | Date