Leon E. Brown, M.D., P.A.; Board Certified Dermatologist
7610 Carroll Avenue, Suite #460; Takoma Park, MD 20912-6321
Tel: (301) 270-5400; Fax: (301) 270-5402

PATIENT'S CONSENT

PATIENT'S NAME (LAST):_____(FIRST):_____Middle:____
SS#: _____ -_____-_____ Date of Birth: _____/_____/_____

CONSENT FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION:

It is our policy to take every measure to protect the privacy of your health information; however, your protected health information may be used and disclosed in order for us to carry out treatment, payment, or health care operations. For our policies regarding the protection of your health care information, please refer to our Notice of Privacy Practice. It is your right to review our policies prior to signing this consent. The terms in the Notice of Privacy Practice may with time, be revised, but a current notice will always be available in our office.

As stated in our Notice of Privacy Practice, you have the right to restrict how we use your protected health information in order to carry out treatment, payment, or health care operations; however, we are not required to agree to these restrictions. If we do agree to these restrictions, the restriction will be binding on the provider.

You have the right to revoke this consent in writing to the extent that we may have already taken action before we received such request.

(TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN):

I acknowledge receipt of the Privacy Notice and consent to the disclosure of my health information for the purpose of treatment, payment, and health care operations.

Signed _____ Date _____

PAYMENT POLICY:

I certify that the information I have reported regarding my insurance coverage is correct and that any services not covered under my insurance plan will be my responsibility. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any all charges for the patient named above

Signed _____ Date _____

ASSIGNMENT OF BENEFITS:

I authorize Dr. Leon E. Brown to apply for benefits on my behalf for the covered services rendered. I request that payment be made directly to the above named provider; in the case of Medicare part B "Benefits and Medigap Benefits" to myself or the party who accepts assignment. I permit a copy the authorization to be used in place of its original. I further understand that certain circumstances may necessitate this authorization to be revoked by wither the provider or the above named carrier, at any time in writing.

Signed _____ Date _____

FOR NOTICE OF PRIVACY FORM ASK FRONT DESK FOR A COPY

Leon E Brown MD
7610 Carroll Avenue, Suite 460
Takoma Park, MD 20912
(301)270-5400

PRIMARY INSURANCE HOLDER/ PARENT INFORMATION

Last Name _____ Social Security #

Suffix (Jr, Sr) _____ Sex M F

First Name _____ Race Amer Indian Asian Black Caucasian Mixed Other

Middle Name _____ Ethnicity (Hispanic) Yes No

Address _____ Preferred Language _____

City State, Zip _____ Marital Status S M D W

Home Phone (___) ___-____ Occupation_____

Work Phone (___) ___-____ Birth Date / /

Cell Phone (___) ___-____ Employment Status FT PT Retired Not

Employer _____ Student Status Not FT PT

Emergency Contact: _____ Phone Number: (___) ___-____ Relationship:

_____ _____

Date **Signature of Parent or Guardian**

Staff Only Verified Information Initials _____