Hines Dermatology Associates, Incorporated

Medical Photography Consent Form

I, _____
First Name Last Name Date of Birth

Consent to medical images being made of me or my child/dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:
(please check below to show consent)

____ placed in my medical record for future treatment
____ sent to my treating health-care
____ used by health professionals for education and training
____ used in health-care publications
____ used on the Hines Dermatology Associates, Inc. Web site

By signing below, I confirm that I understand this consent form.

_____ _____
Signature of Patient/Parent or Guardian Date

_____ _____
Signature of Doctor/Health Professional/Staff Date

Hines Dermatology Associates, Incorporated

Patient Form – Office Visits

___ New ___ Updated ___No Change

NAME _____

STREET _____

CITY, STATE, ZIP _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ SEX _____

EMPLOYER'S NAME & ADDRESS _____

_____

_____

DRIVER'S LICENSE # _____ STATE OF ISSUE _____

BILLING ADDRESS (if different from above) _____

_____

PHYSICIAN NAME _____

ADDRESS _____

PHONE _____

PERSON TO CALL IN CASE OF EMERGENCY _____

RELATIONSHIP _____

PHONE _____

AUTHORIZATION FOR A MINOR _____

I _____, HEREBY REQUEST AND AUTHORIZE HINES DERMATOLOGY ASSOCIATES, INC. CLINICIANS AND ITS VENDORS TO PROVIDE DIAGNOSTIC AND TREATMENT PROCEDURES IN ACCORDANCE WITH ACCEPTED THERAPEUTIC PRACTICES THAT ARE DEEMED NECESSARY TO PROPERLY STUDY AND TREAT MY OR MY SON'S/DAUGHTER'S (name) _____INDIVIDUAL CASE.

SPECIAL COMMUNICATION ARRANGEMENTS. YOU HAVE THE RIGHT TO REQUEST US TO COMMUNICATE HEALTH INFORMATION TO YOU IN A CERTAIN WAY OR AT A CERTAIN LOCATION. FOR EXAMPLE, YOU MAY ASK US ONLY TO CONTACT YOU AT WORK. SUCH REQUESTS MUST BE SUBMITTED IN WRITING TO HINES DERMATOLOGY ASSOCIATES, INC. YOU MUST INCLUDE WITH YOUR WRITTEN REQUEST AN ALTERNATIVE LOCATION OR METHOD OF CONTACT. WE WILL ACCOMMODATE ALL REASONABLE REQUESTS OF THIS TYPE.

(PLEASE CONTINUE TO NEXT PAGE)

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

PARENT or PERSON RESPONSIBLE FOR ACCOUNT

NAME _____

RELATIONSHIP TO PATIENT _____

ADDRESS (if different from above) _____

EMPLOYER'S NAME & ADDRESS _____

_____

DATE OF BIRTH_____

SIGNATURE OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE

INSURED'S NAME (if other than patient) _____

RELATIONSHIP TO PATIENT _____

INSURED'S DATE OF BIRTH _____

INSURED'S EMPLOYER _____

INSURANCE COMPANY NAME & ADDRESS _____

_____

POLICY # _____

GROUP/PLAN # _____

SECONDARY INSURANCE

INSURED'S NAME (if other than patient) _____

RELATIONSHIP TO PATIENT _____

INSURED'S DATE OF BIRTH _____

INSURED'S EMPLOYER _____

INSURANCE COMPANY NAME & ADDRESS _____

_____

POLICY # _____

GROUP/PLAN # _____

(PLEASE CONTINUE TO NEXT PAGE)

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

I hereby authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to Hines Dermatology Associates, Inc.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

Patients are expected to have the necessary referral, depending on insurance coverage, at the time of visit. Otherwise, the patient is responsible for payment.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are files, coverage will be preverified and you will be asked to pay any unmet deductible, noncovered services and copayments.

We reserve the right to charge for any appointment not cancelled or rescheduled within 24 hours of the original appointment. $75.00 will be charged.

A finance charge of 1.5% per month (18% per annum) will be charged on all past-due accounts. Also, you will be responsible for all costs of collection plus reasonable attorney fees.

I have completed the above information and certify this information is true and correct to the best of my knowledge. I will notify you of any change in the above information.

PATIENT'S SIGNATURE_____ DATE _____

PARENT (if patient is a minor) _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

NO CHANGE _____ DATE _____

Hines Dermatology Associates, Incorporated

I have received a copy of the

"Notice of Privacy Policies and Information Practices" for

Hines Dermatology Associates, Inc.

_____

Print Name

_____ _____

Signature Date