ADVANCED DERMATOLOGY & SKIN CANCER CENTER

FINANCIAL/HIPAA DISCLOSURE

By signing below I am confirming I have read the Financial Policy, had the opportunity to ask questions, have been provided a "hard copy" if so requested, and fully understand the terms.

I authorize any holder of medical or other information about me to release to my Insurance Company, or its intermediaries or carrier, and information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to insurance assignment of benefits apply.

_____ _____/_____/_____
Signature Date

If you have a supplemental policy and it is a secondary policy to which your insurance automatically "Crosses over", we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____
Signature Date

Our Notice of Privacy Practices provides information about how we many use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy at any time. You may fine our Notice of Privacy Practices on our website at www.advancedskinmd.com . You may request a copy any time at the office.

Have you been provided a copy Notice of Privacy Practices? YES ☐ NO ☐

What is your preferred method of contact? ☐ Phone ☐ Email ☐ Text Message

May we leave a detailed message on your voice mail? YES ☐ NO ☐

May we text/email appointment reminders/practice information? YES ☐ NO ☐

Would you like to access your medical records on our patient portal? YES ☐ NO ☐

Email address:_____

Do you give our office permission to discuss your medical information with family members?

☐ YES ☐ NO If yes, please provide then name and phone number:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

_____ _____ _____/____/____
Printed Name—Patient or Representative Signature Date

Relationship to Patient (if other than patient):_____

Witness: _____ _____ _____/____/____
Printed Name—Practice Representative Signature Date

Revised: 09/15/2014