BETTY RAJAN, M.D., P.L.L.C.
Dermatology & Skin Care

GENERAL PATIENT AUTHORIZATION

I hereby authorize physicians of Betty Rajan, MD to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice. In consideration of services rendered or to be rendered, I assign and transfer to Betty Rajan, MD any benefits payable to me or on my behalf under any insurance coverage. I agree to fulfill all policy provisions which my insurance companies may require for payment. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I further agree to pay for any items or services not covered by the Medicare Program. I hereby understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract. If my insurance company does not pay for services rendered to me within 90 days, I understand and agree to pay any outstanding balance. I understand that I am responsible for the total charges for services rendered which my include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Betty Rajan, MD. I further understand should this account become delinquent; I shall pay the reasonable attorney or collections expenses. I understand that if I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services.

I authorize Betty Rajan, MD to release medical information pertaining to my diagnosis and/or treatment, laboratory test results, medical history, treatment, or any other such related information to:
Medicare or Medicaid, my insurance company or its designated representatives, any person(s) or entities financially responsible for my care or treatment, representatives of local, state, or federal agencies in accordance with law, employees or representatives of Betty Rajan, MD for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Betty Rajan, MD or the employees of Betty Rajan, MD.

_____
Signature of Patient/Legally Authorized Representative

_____
Date

_____
Relationship

_____
Print Name

6600 Bryant Irvin Rd | Fort Worth, TX 76132 | Office:817-820-0011 | FAX:817-820-0073 | Email:info@bettyrajan.com | Web: http://BettyRajan.com

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I hereby give permission to Betty Rajan, MD to notify me by phone or email of the following:

❑ Yes ❑ No Appointment reminder, either by personal message or recorded message

❑ Yes ❑ No A message to call the office for test results. Actual test results will not be left by message.

List any individuals who you authorize to receive the above information on your behalf:

_____

I authorize Betty Rajan, MD to disclose my medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, or any other such related information to these listed below (physician, family member):

_____

Name Telephone # Relationship

_____

Name Telephone # Relationship

_____

Name Telephone # Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

_____ _____

Signature of patient/Legally authorized representative Date

_____ _____

Print Name If a legal representative. Relationship to patient

Minor Patients, if applicable

I give my permission for Betty Rajan, MD to examine and treat _____, my minor child, in your office without me being present. Any procedures require a parent being present. DOB: _____

_____ _____ _____

Print Parent or guardian name Parent or guardian signature Date

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PRACTICE POLICIES

In order to serve your needs better, we ask that you read our policies and sign below.

1. We request a 24 hour cancellation notice. Failure to call, "no shows," will be charged a $30 administrative fee that is not billable to insurance. Surgery and cosmetic "no shows" will be charged $50.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy to request refills.
3. Co-pays and deductibles are due at the time services are rendered.
4. Patients are responsible for verifying insurance coverage.
5. We attempt to make courtesy phone calls to remind you of your appointment but are unable to provide this service at all times. If you do not receive a reminder phone call and miss your appointment, this does not cancel our "no show" policy above.
6. All returned checks will be charged a $30 administrative fee.
7. If past bills are sent to collections, there will be a surcharge to cover the cost of the collection agency.

PATIENT HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to abide.
- The patient may revoke this authorization in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Authorization.

I acknowledge that I have read the above authorization and have had access to read Betty Rajan, MD's full Notice of Privacy Practices.

_____ _____

Printed Name – Patient or Representative | Relationship to patient (if other than patient)

_____ ____/____/_____

Signature | Date

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