H2|DERMATOLOGY

HIPAA/Patient Consent Form

HIPAA Consent:

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. H2 Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations;
2. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions;
3. The patient may revoke this Consent in writing at any time and all future disclosures will then cease;
4. The Practice may condition receipt of treatment upon the execution of this Consent;
5. A copy of this notice was posted in a clear location, available to read, and a copy may be requested in person, by mail, or by phone during normal business hours.

By signing below I acknowledge that I have read and understand all of the above statements.

Printed Patient Name: _____ Patient DOB: _____/_____/_____

Patient or Guardian Signature: _____ Date: _____/_____/_____

Informed Patient Consent:

1. I authorize my physician to release any information, including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such medical care, to third party payers including, Medicare and Medicaid.
2. I authorize and request that my insurance company, in lieu of reimbursing me directly, pay the doctor or medical office any benefits for services rendered.
3. Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures/treatment regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with procedures/treatment, it is my responsibility to request an estimate prior to starting procedures/treatment.
4. I understand that my insurance company carrier may pay less than the actual bill for services; I agree that it is my responsibility for payment of all services rendered on my behalf or my dependents.
5. I understand I may be billed by an outside laboratory for work that was performed in the office, if my insurance company does not have a contracted lab or facility, or if the services are not covered by my insurance company.
6. I understand that I am responsible for all co-pays as well, and that they are due at the time of service.
7. I will notify H2 Dermatology if/when there are pertinent changes to my medical history, including medical conditions and changes in insurance carriers. I will also notify the office of any changes in my contact information.
8. I will notify H2 Dermatology 48 hours in advance if I am unable to make my scheduled appointment, with any of H2 Dermatology providers, including physicians, physician assistants, nurse practitioners, and cosmetic appointments with nurse injectors. I may be responsible for a $50.00 “no show fee” if I fail to do so.

By signing below I acknowledge that I have read and understand all of the above statements.

Printed Patient Name: _____ Patient DOB: _____/_____/_____

Patient or Guardian Signature: _____ Date: _____/_____/_____