Ideal Dermatology: HIPAA Acknowledgement Form

Patient Name: _____ Date of Birth: _____

HIPAA Acknowledge and Consent (Please initial below):

_____ I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health care information for its treatment, payment, health care operations, and other described and permitted uses and disclosures.

_____ I agree that the practice may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes. I give permission for my Protected Health Information to be disclosed for purposes of billing and payment, communicating results, findings, and care decisions to the people designated below. Information will not be released without authorization, even to family members.

Name	Relationship	Contact Number
_____	_____	(___)_____
_____	_____	(___)_____

_____ Please initial if we may leave a detailed phone message regarding your medical or billing information. Please list phone number we may use (_____) _____

Financial Responsibility Policy Assignment and Release:

1. I have insurance coverage and assign all medical benefits, if any payable to me for services rendered.
2. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
3. I authorize the use of this signature on my insurance submissions.
4. I am aware it is my responsibility to contact my insurance company to verify that it will pay for charges incurred and I understand that I am financially responsible for all charges whether or not paid by insurance.

Please initial the following IF IT APPLIES to your visit today: _____ I understand that I HAVE NOT brought proof of my insurance today and that my network benefits cannot be verified at the time of service. _____ I understand that I DO NOT have or do not wish to provide my medical insurance for claim and I will be billed as a SELF PAY patient for all services rendered.

Patient/Guardian Name (Print): _____Date:_____
Signature: _____

*By signing this form, I certify that I have read, fully understand, and agree to ALL of the above statements.