Ideal Dermatology:

HIPAA Acknowledgement, PHI Consent and Financial Responsibility Form

Patient Name: ____ Date of Birth: ____________________

_______ Please initial if we may leave a detailed phone message regarding your medical or billing information. List a phone number we may use and select what type it is: (_____)________________ is a: ___Home ___Cell

HIPAA Acknowledgement (Please initial below):

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

PHI Consent (Please initial below):

_______ I give permission for my Protected Health Information (PHI) to be disclosed for purposes of billing and payment as well as communicating results, findings, and care decisions to the people designated below. Information will not be released without authorization, even to family members. 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.

Name (If none, write "N/A" on both lines)	**Relationship** (e.g.: spouse, adult child, parent, etc)	**Contact Number**
_____________________________	___________________________	(_______)_______________________
_____________________________	___________________________	(_______)_______________________

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 **ONLY 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.