Johnson Dermatology Consent Form

I. Consent to Treatment

I voluntarily consent to receive medical and health care services that may include examinations, diagnostic procedures, and treatments. If patient is under the age of 18, or over 18 and are unable to consent for themselves, I give permission for the patient to receive follow-up care from the physicians and staff at Johnson Dermatology Clinic in my absence. I also understand that any copays/fees for services the patient receives are due at time of service.

II. Assignment of Benefits

I authorize my insurance company to make direct payment to the provider of services for the professional or medical expense benefits allowable under my current insurance policy. I authorize appeals to be filed to my insurance company if needed. I understand that if my insurance company is out-of-network, open or a nontraditional plan, Johnson Dermatology will provide a claim form so that I may file on my insurance and I will be responsible for payment in full at time of service.

III. Financial Responsibility

I agree to pay all charges for medical or other services not covered by my insurance company. I further understand that I am responsible for all collection and/or attorney fees necessary to collect this debt as governed by the Johnson Dermatology Financial Policy on the reverse side. In the event that Johnson Dermatology has made reasonable attempts to file claims to the insurance company for which I have provided information and direct payment is not received within 60 days of the date of service, I may be fully responsible for charges incurred.

IV. HIPAA Consent

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that governs the use and disclosure of a person's health information. The following statements cover the basics of your rights as a patient under HIPAA.
I acknowledge I have received a copy of the Notice of Privacy Practices. Johnson Dermatology reserves the right to change the Notice of Privacy Practices.

By my signature I certify that I have read the four sections above, and agree to the above

statements. Patient Name (please print):

_____

Authorized Rep:_____Relationship to Patient: _____

Signature:_____Date: _____
(Signature of Patient or Authorized Representative)