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, I give permission for the patient to receive follow-up care from the physicians and staff at Johnson Dermatology Clinic in my absence.

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. That is, my insurance company will make direct payment to Johnson Dermatology for services rendered rather than to myself.

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.

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.

- Protected health information may be disclosed for treatment, payment, or health care operations.
- Johnson Dermatology has a Notice of Privacy Practices and the patient has an opportunity to review this notice. To obtain a copy of this notice ask the office staff. Johnson Dermatology reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of his or her protected health information but Johnson Dermatology does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease,
- Johnson Dermatology may offer or refuse treatment based upon the execution of this consent.

By my signature I certify that I have read the four sections above, agree to the above statements, and have been given Johnson Dermatology's Financial Policy.

Printed Name of Patient or Responsible Party: _____

Signature: _____ Date: _____