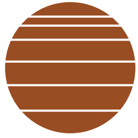

Preston Ridge Dermatology, PC
3155 NORTH POINT PKWY BLDG. E, SUITE 100
ALPHARETTA • GA 30005
Phone: 770.475.6222

PATIENT CONSENT

Our Notice of Privacy Practices information about how we may use and disclose protected health information about you. The Notice contains a patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. 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. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

-Protected health information may be disclosed or used for treatment, payment, or health care operations.
-The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
-The Practice reserves the right to change the Notice of Privacy Practices.
-The patient has the right to restrict the uses of their information but the Practice 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.
-The Practice may condition receipt of treatment upon execution of this Consent.
-This Authorization remains valid until patient withdraws from Practice.
-With this consent we may call my listed phone numbers and leave a message on voice mail or in person in reference to any items that assist our Practice, such as appointment reminders, insurance items, calls pertaining to clinical care (including test results), Accounts Receivable, among others.

I request payment of authorized Medicare/insurance benefits be made on my behalf to Preston Ridge Dermatology for any services furnished by Preston Ridge Dermatology or its staff. I authorize any holder of medical information about me to release to my insurance company, and its agents any information needed to determine these benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, or insurance companies contracted with this provider, the provider agrees to accept the charge determination of the Medicare carrier or insurance company as the full charge and I am responsible only for the deductible, coinsurance and non-covered services.

WAIVER OF LIABILITY

All insurance companies, including Medicare, only pay for services that they determine to be ‘reasonable’ and necessary. If your insurance company determines that a particular service is not reasonable and necessary under their program standards, they will deny payment for the service:

Insurances usually do not pay for cosmetic procedures.

I have read the payment policy of Preston Ridge Dermatology and do agree to be bound by its terms. I also understand there is a $25 fee for returned checks and missed appointments, and I agree to pay all charges for my medical care services not covered by my insurance company.

Please list names of people we have permission to discuss your medical care with:

Name (please print): ______________________________ Relationship:______________________________

Name (please print): ______________________________ Relationship:______________________________

This Consent was signed by: ____
PRINT NAME-PATIENT OR REPRESENTATIVE

____
SIGNATURE DATE

Relationship to Patient (if other than patient):____