CONSENTS & RELEASES

Dermatology & Skin Surgery Center

210 Village Center Pkwy
Stockbridge, GA 30281
www.dermandskin.com
(770) 474-5952

Consent for Treatment

I, _____, hereby voluntarily consent to patient care at Dermatology & Skin Surgery Center, PC (DSSC) encompassing routine examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the medical provider. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians, physician assistants and/or medical assistants as is necessary.

(Please initial all sections below)

Notice of Patient Privacy Consent (HIPAA)

____ I have been provided with a copy (electronic and/or printed copy) of the practice's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at www.dermandskin.com for your convenience.)

Authorized Release of Medical Information

There are times where the physicians and employees of DSSC need to contact you. Our primary method is through your patient portal, however, circumstances may require us to contact you via mail, email, telephone, voice mail, and/or text messaging.

I authorize the release of medical information to the following: _____,
Name and Relationship

_____,_____
Name and Relationship *Name and Relationship*

Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

____ I hereby consent to DSSC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to DSSC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations.

Lifetime Medicare Authorization & Consent for Medicare Patients Only

____ I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount. I understand that I am responsible for my health insurance deductible and coinsurance.

Terminating Services

____ All the providers at DSSC value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections.

If the relationship is terminated, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice and will send medical records to a new provider with a written release.

_____ _____

Patient/Guardian Signature *Date*

_____

Patient/Guardian Printed Name