All Dermatology
ARROWHEAD · BILTMORE/ARCADIA · SURPRISE

**HIPPA CONSENT FORM**

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, (PHI, protected health information) and other documents or information. Record requests can take up to 30 days with a $35.00 charge assessed to the patient. Requests from physicians will be done at no charge.

We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

It is the policy of this office to remind patients of their appointments. We may do this by telephone or e-mail.

**I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**ASSIGNMENT OF BENEFITS**

I acknowledge that all the information given is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to All Dermatology, Inc., for any services furnished to me.
I hereby consent to the administration and performance of all diagnostic procedures and /or treatments which in the judgment of All Dermatology, Inc. may be considered necessary and advisable. I also authorize the release of any information required to process insurance claims including any information relating to alcohol, drug abuse, and/or. I authorize the release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians, and others involved in the medical and/or financial aspects of my medical care. This authorization may be revoked in writing by me at any time.

Cancellations require a 24-hour notice, or a $50.00 charge will be assessed to the patient.

**Signature: _____ Date_____**
**(of Patient) or (Legal Representative stating relationship to patient)**