

NOTIFICATION/ACKNOWLEDGEMENTS

Patient Name:

Acct #:

Physician:

Location:

Contact Information

Dallas Associated Dermatologists would like to contact you for various reasons, including Personal Health Information (PHI) related to Appointment Reminders, Appointment Recalls and Notification of Test Results.

Yes, you may leave PHI at the Primary Telephone Number and E-Mail address I provided.

No, do not leave PHI.

Notice of Privacy Practices Written Acknowledgement Form

I acknowledge that Dallas Associated Dermatologists has made the Notice of Privacy Practices available. Do you give our office permission to discuss your private health information with other parties?

Yes No If yes, please provide their names.

Spouse (List Name): _____

Parent (List Name): _____

Parent (List Name): _____

Other (List Name): _____

Payment of Services and Notice Regarding Insurance

If you do not have active Medical Insurance, payment will be required in full at the time of your visit.

If you have active Medical Insurance under a Plan in which we do not participate, payment of 50% of the billed charges will be required at the time of your visit. Any remaining balance, after payments or adjustments, will be your responsibility.

If we are filing insurance for your visit, we must have complete information, and any required referral information, at the time of your visit. If you cannot provide us with this information, we will not be able to file your claim and payment in full will be required at the time of your visit.

If we are able to determine that services provided will be charged against your Plan Deductible, such as surgical or office procedures, that amount may be due at the time of your visit, in addition to any Co-Pay or Co-Insurance.

Patient/Guardian Signature: _____ **Date:** _____