

DERMATOLOGY ASSOCIATES OF NORTHERN MICHIGAN, P.C.

PATIENT ACKNOWLEDGEMENT OF HAVING READ OR BEEN READ THE NOTICE OF PRIVACY

I have been provided the opportunity to read, or it has been read to me, the Notice of Privacy Practices at Dermatology Associates of Northern Michigan, P.C. I understand that Dermatology Associates of Northern Michigan, P.C. is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at Dermatology Associates of Northern Michigan, P.C. and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Dermatology Associates of Northern Michigan, P.C. but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, assess or amend my health information.

I understand that Dermatology Associates of Northern Michigan, P.C. is required to maintain the privacy of my health information. Dermatology Associates of Northern Michigan, P.C. will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operation. Examples of disclosures that do not require my authorization may include access to my health information by Dermatology Associates of Northern Michigan, P.C. staff, physicians, billing to myself and/or a third-party payer. In addition, business associates of Dermatology Associates of Northern Michigan, P.C. from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place insuring the protection of my health information. Upon the physicians' best judgment, Dermatology Associates of Northern Michigan, P.C. may disclose to a family member, relative or close personal friend or any other persons I identify, health information relevant to that person's involvement in my care. My healthcare information may also be used for research data, organ procurement, FDA, public health or legal authorities, and/or law enforcement purposes.

Dermatology Associates of Northern Michigan, P.C. may contact me regarding appointment reminders, changes or cancellations by the following means: by mail, using postcards or letters; by telephone calls to my home or place of employment, leaving a message with the person answering the phone if I do not personally answer the telephone; and by leaving a voice mail or answering machine messages at my home or place of employment.

I have read and understand the Notice of Privacy Practices at Dermatology Associates of Northern Michigan, P.C.

Print Patient Name

Birth Date

Patient Signature

_____ Refused to Sign (explained below)
Date

Witness

DERMATOLOGY ASSOCIATES OF NORTHERN MICHIGAN, P.C.

PATIENT ASSIGNMENT OF BENEFITS

This allows us to bill and accept direct payment from your insurance company or other payer.

Dermatology Associates of Northern Michigan, P.C. will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive. I hereby assign to Dermatology Associates of Northern Michigan, P.C. any insurance or other third party benefits available for healthcare services provided to me. I understand that Dermatology Associates of Northern Michigan, P.C. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Dermatology Associates of Northern Michigan, P.C., I agree to forward to Dermatology Associates of Northern Michigan, P.C. all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. I understand that my signature requests that payment be made directly to Dermatology Associates of Northern Michigan, P.C. I authorize release of medical information necessary to pay the claim. A photo copy of this assignment is considered as the original.

PATIENT ACKNOWLEDGEMENT AND AUTHORIZATIONS

This allows us to evaluate and treat you, and to bill and communicate with your insurance company.

I authorize Dermatology Associates of Northern Michigan, P.C. to conduct examinations, and perform procedures as are medically required and administered treatment and medications as deemed necessary or advisable. I authorize Dermatology Associates of Northern Michigan, P.C. to release a complete report of services rendered diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's worker's compensation insurance company, or other third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered. I authorize that payment of benefits be made on my behalf to Dermatology Associates of Northern Michigan, P.C. furnished to me. I understand that I am financially responsible to Dermatology Associates of Northern Michigan, P.C. for: charges not covered by this assignment and/or charges for services without an appropriate referral by a Primary Physician when required by my insurance plan.

I authorize any holder of medical information about me to release to the insurance company and its agents and information needed to determine these benefits or the benefits payable for related services. Including (if any):

- Alcohol and drug abuse records protected under the regulation in 42 code of Federal Regulation, Part 2;
- Psychiatric/psychological services records, social work records; and
- Any information regarding serious communicable diseases and infections as defined by Michigan Department of Public Health Code (Act 368 or 1978 as revised), which includes venereal disease, tuberculosis, HIV, AIDS or ARC.

I understand that if my physician, or any person employed by or under the direction and control of my physician, is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

I HAVE READ THE ABOVE PATIENT ASSIGNMENT OF BENEFITS, PATIENT ACKNOWLEDGEMENT AND AUTHORIZATIONS UNDERSTAND ALL OF THE INFORMATION ABOVE. I UNDERSTAND THE TERMS AND CONDITIONS OUTLINED HEREIN AS CONFIRMED BY MY SIGNATURE BELOW.

PATIENT (GUARANTOR) SIGNATURE

PATIENT'S PRINTED NAME

DATE

PATIENT'S AGE*****

*****NOTICE: If patient is a minor (under 18 years of age) the parent of responsible party must complete and sign the Consent for Treating a Minor Form