Patient Name: _____ **Date of Birth:** _____

Email *(intent to use patient portal):* _____

HIPAA Acknowledgement and Consent Form (*Please initial below):*

_____I am aware the Notice of Privacy Practices, which describes how Lake Loveland Dermatology may use and disclose my healthcare information for treatment, payment, healthcare operations and other uses or disclosures, is available for review at my request.

_____ I agree that the practice may request and use my prescription history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Disclosures to Family/Friends:

1. _____ _____ _____
2. _____ _____ _____

Name *Phone* *Relationship*

_____ Please initial if we may leave a detailed phone message regarding your medical or billing information.

Please list the phone number we may use. (_____) _____

Financial Responsibility Policy

Assignment and Release

1. I have insurance coverage and assign all medical benefits, if any, payable to me for services rendered.
2. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
3. I authorize the use of this signature on my insurance submissions.
4. I am aware it is my responsibility to contact my insurance company to verify that it will pay for charges incurred and I understand that I am financially responsible for all charges whether or not paid by insurance.

Please initial the following IF IT APPLIES to your visit today:

_____ I understand that **I HAVE NOT** brought proof of my insurance today and that my network benefits cannot be verified at the time of service.

_____ I understand that **I DO NOT** have or do not wish to provide my medical insurance for claim and I will be billed as a SELF PAY patient for all services rendered.

Print Patient/Guardian Name: _____ Date: _____

Signature: _____

By signing/initialing this form, I certify that I have read, fully understand, and agree to all of the above statements.