CONSENT FOR CARE ASSIGNMENT OF BENEFITS ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name				DOB				
Las	t Fir	st	M.I.	manufact.				
Guardian Name	¥			_DOB				
Las	II 53		M.I.					
I, the undersigned, co purpose of carrying o	out my treatment, o	nd disclosure of btaining payme	t my protecent for my	cted health in health care o	nformation been for carrying	y Precision D g out health	ermatology, P care operation	.A. for the s.
I understand that I had given the opportunity Practices provides into A copy of this notice	y to review Precision formation about ho	n Dermatology' w Precision Dei	's Notice o rmatology,	f Privacy Prac	tices or to re	quest a copy	of it. The No	tice of Privacy
Precision Dermatolog may obtain a revised for one at the time of	Notice of Privacy Pr	right to changeractices by calling	e the priva ng the offic	cy practices t ce and reques	hat are desc sting a revise	ribed in the d	Notice of Priva ent in the mail	cy Practices. or by asking
I acknowledge that I I treatment, obtaining Dermatology, P.A. is a such restrictions will I writing.	payment for my he not obligated to agr	althcare or for ee to any such	carrying ou restriction:	it healthcare s. If Precision	operations. Dermatolog	However, I u	understand tha	nt Precision
My "protected health and which relates to r past, present or futur	ny past, present or	future physical	or mental	health or cor	created or r	eceived by P Provision of h	recision Derma	atology, P.A. me or to the
I hereby assign all me and/or any health pla Precision Dermatolog services and/or any he services. This assignm valid as an original. It services are being prowhether or not paid b	n to: Precision Dern y, P.A. to release an ealth plan to the ext ent will remain in e understand that I ar vided to a minor, th	natology, P.A. fo y medical infor ent such inforr offect until revo n financially res	or any servenation to mation is no ked by me sponsible f	rices furnisher such private i eeded to deta in writing. A or all charges	d me by Pred insurance, the ermine bene a photocopy of whether or	cision Derma e Centers fo fits or benef of this assign not paid by	tology, P.A. Ta r Medicare and its payable for iment is to be	authorize d Medicaid related considered as
I agree that I will pay a that all applicable co-p Dermatology, P.A. has appointment time will to the appointment w	a \$25 fee for return result in a \$25 fee.	n specialty care ned checks, and Furthermore,	will be col my failure	lected on the e to cancel a f	day of servi	ce. I further pointment w	acknowledge	that Precision
A photocopy of this co	nsent and assignme	ent of benefits i	is to be cor	nsidered as va	alid as the or	iginal.		
Signature of Patient or	Personal Represen	tative	Date					
Name of Patient or Per	sonal Representati	e	Description	on of Persona	Il Renresenta	tivo's Autho	rity	

Description of Personal Representative's Authority