KEYSTONE DERMATOLOGY
& CENTER FOR SKIN SURGERY

HIPPA PRIVACY POLICY

I give permission for the following individual/s to receive my medical information and results.

Name: ______________________ ***Relationship:*** ____________ ***Phone#:*** ______________

Name: ______________________ ***Relationship:*** ____________ ***Phone#:*** ______________

Notice of Patient Rights & Privacy Practices Acknowledgement:

- I acknowledge that I have rights as a patient, and I have responsibilities as a patient. Your signature below indicates that you have been offered a copy of the Notice of Privacy Practices that has been posted at Keystone Dermatology & Center for Skin Surgery (KDCSS). Every attempt will be made to obtain this written acknowledgement.

Consent for Treatment & Photography:

- I voluntarily present to KDCSS for medical evaluation, diagnosis, and/or treatment. I understand that any patient under the age of 18 must be accompanied by a parent or guardian in order to receive treatment. I consent and authorize my provider(s) or his or her designee(s) to provide diagnostic and therapeutic treatment and digitally photograph the progress of my care, which may be necessary or advisable in their professional judgment. By signing this consent form I acknowledge my right to refuse recommended tests or treatments.

Payment for Services & Assignment of Benefits:

- I understand that, regardless of my assigned benefits, I am financially responsible for payments or services rendered to me. If the providers involved in my care accept third-party reimbursement for all or part of the services I receive, I hereby agree to assign such benefits to KDCSS and authorize my insurance company, or other entity, to make payment directly to KDCSS. I understand that KDCSS may disclose a limited amount of health information to third-parties to obtain payment for health care services provided.

- I agree to pay co-payments, co-insurance, deductibles and outstanding balances, including payments for missed or "no-show" cosmetic appointments or surgeries that were previously scheduled or agreed upon. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses. I certify that the information given by me in applying for payment under any insurance or Medicare program is correct.

______________________	______________________	____________
Print Name of Patient	***Signature of Patient***	***Date***