DARABI
DERMATOLOGY

# General Consent and HIPAA Policy

**CONSENT FOR TREATMENT:** By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include lab tests, procedures such as biopsies and destructions, and other diagnostic tests. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatment, tests, and procedures and that I have the right to refuse his/her recommendations.

**BILLING AUTHORIZATION:** I hereby authorize Darabi Dermatology to release requested medical information to my insurance company to collect payment for any charges.

**ASSIGNMENT OF BENEFITS:** I hereby request that payment of insurance benefits be made directly to Darabi Dermatology on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to services for myself or my dependent. It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay any balances promptly. For details, our Financial Policy has been made available to me in clinic and on our website.

**MEDICARE AUTHORIZATION:** I request the payment of authorized Medicare benefits be made on my behalf to Darabi Dermatology for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as noncovered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those services rendered. For details, our Financial Policy has been made available to me in clinic and on our website.

**PATIENT'S RIGHT TO PRIVACY:** I acknowledge I have been made aware of Darabi Dermatology's HIPAA Privacy Practices that pertain to my rights regarding the use and disclosure of my protected health information. These rights are more fully described in this office's Notice of Privacy Practices. I understand a copy of Darabi Dermatology Privacy Practices is available to me on the practice website or in the office upon my request. I consent to be contacted by Darabi Dermatology or other business associates at the physical address, phone numbers and emails provided.

**BLOOD TESTING:** I understand that while receiving care, a healthcare worker may accidentally be exposed to my blood or other bodily fluid. If this rare event occurs, I consent to my blood being tested for the presence of infectious diseases to protect the health care worker and I be made aware of my test results.

**ELECTRONIC PRESCRIBING:** I authorize Darabi Dermatology to retrieve my medication history from my pharmacy through their e-prescribing system and import my current medications into my electronic medical record.

**PHOTOGRAPHY AND MARKETING:** I consent to my pictures being taken for medical records, communication with other health care providers involved in my care. For publications and marketing materials without revealing my identity. I consent to being contacted for marketing and informational updates about the practice via text, call or email.

**HIPAA Information**

I authorize Darabi Dermatology to discuss **all aspects** of my protected health information including but not limited to appointments, medical diagnoses, tests results, prescription information and financial information with the following individuals:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone:_____

**Signature:** _____ **Name (Print):**_____ **Today's Date:** _____