Patient Consent Form

PMS ID: Sex: DOB: Phone: MRN:

PATIENT INFORMATION							
LAST NAME	FIRST NAME	M.I.	SSN	DATE OF BIRTH	SEX	MRN	
STREET ADDRESS			STREET ADDRESS CONTD.				
CITY	STATE	ZIP CODE	HOME PHONE	CELL PHONE			

HIPPA

HIPPA STATEMENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Witness Signature 11/30/2018

Patient / Agent / Guardian Signature 11/30/2018

FINANCIAL STATEMENT

FINANCIAL STATEMENT

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I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. All court fees, attorney's fees or other fees necessary to collect this account are payable by me. I have read all the information on the History and Intake form and completed all the answers. I have filled out the demographics form with all my current information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or pertinent information to keep my records up to date at Nielsen Dermatology.

MEDICARE PATIENTS:

WE WILL ACCEPT ASSIGNMENT WITH MEDICARE ON SERVICES RENDERED TO MEDICARE PATIENTS.

I UNDERSTAND THAT I WILL BE RESPONSIBLE AT THE TIME OF SERVICE FOR THE MEDICARE 20% CO-INSURANCE AND ANY PART OF MY MEDICARE DEDUCTIBLE THAT HAS NOT BEEN MET

LABORATORY FEES:

ALL SURGICAL PATHOLOGY AND OTHER LAB SPECIMENS ARE SUBMITTED TO OUTSIDE LABORATORIES FOR PROCESSING THEN RETURNED TO DR. NIELSEN FOR ANALYSIS.

I UNDERSTAND THAT I MAY RECEIVE A SEPARATE BILL FROM THE LABORATORY THAT PROCESSES MY SPECIMEN.
I UNDERSTAND THAT I MUST CONTACT THE LABORATORY DIRECTLY FOR ANY BILLING QUESTIONS REGARDING THE PROCESSING OF MY SPECIMEN.

FINANCIAL STATEMENT

Witness Signature 11/30/2018

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MEDICAL RECORD RELEASE CONSENT FORM

I hereby authorize _____

Facility/Physician Name

_____

NIELSEN

Patient Consent Form

PMS ID: Sex: DOB: Phone: MRN:

Phone Number Fax Number

to disclose the following protected health information to NIELSEN DERMATOLOGY located at 2620 S. Seacrest Blvd Boynton Beach, Florida 33435 and 24 SE 6th Street Boca Raton, Fl 33432. This authorization will expire in 60 days. My authorization applies to the following information and only this information may be used and/or disclosed pursuant to this authorization.

Date(s) of service:_____

_____ Complete chart _____ Surgeries

_____ Biopsy Report(s) _____ Office Notes

_____ Other

Please Fax the requested records to the office of NIELSEN DERMATOLOGY Medical Records Department at (561) 737-5221 or via postal service to 2620 S. Seacrest Blvd Ste A Boynton Beach, Fl 33435.

I understand that I may revoke this authorization in writing at any time. I am aware that my revocation will not be effective to the extent that NIELSEN DERMATOLOGY LLC has acted in reliance on this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy regulations, then such information may be re-disclosed and no longer protected by the Federal Privacy regulations. I release NIELSEN DERMATOLOGY LLC, its workforce, members from all liability arising from the disclosure of my health information pursuant to this agreement.

I have read the above and authorize the disclosure of the protected health information as stated.

Witness Signature 11/30/2018

Patient / Agent / Guardian Signature 11/30/2018