Boulevard Dermatology
8001 Roosevelt Blvd Ste 307
Philadelphia, PA 19152

Authorizations

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to

Boulevard Dermatology. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patients and to avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa, MasterCard or Discover. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

Patient or Legal Guardian Signature: _____ Date: _____

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, Boulevard Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Boulevard Dermatology Notice of Privacy Practices for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Boulevard Dermatology. With my consent, Boulevard Dermatology may call my home or other designated locations and leave message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory among others. With my consent, Boulevard Dermatology may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent, Boulevard Dermatology may e-mail my home or other designated locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statement. I have the right to request that Boulevard Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Boulevard Dermatology use and disclosure in reliance upon my prior consent. If I do not sign this consent, Boulevard Dermatology may decline to provide treatment to me.

Patient or Legal Guardian Signature: _____ Date: _____

Medicare Health Insurance Form

I request that payment of authorized Medicare benefits be made either to me or my behalf to Boulevard Dermatology for any services furnished to me by Boulevard Dermatology. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient or Legal Guardian Signature: _____ Date: _____