DermacenterMD
Advanced Dermatology & Aesthetic Solutions

Consent/Authorization to Treat

I authorize Advanced Dermatology of Northern Indiana, P.C., its care providers, and staff working under the name of DermacenterMD, to leave messages on my voicemail or answering machine to confirm future appointments. I also authorize messages regarding personal medical information (diagnosis, treatment, procedures, results from procedures/tests) to be left on the above listed voicemail, answering machine, email or Labcalls for notification.

I understand that I (or named patient) require treatment in this facility because of my (their) condition. I permit the provider or his/her employees, students in training, and all other persons caring for me (named patient) to provide treatment in ways they judge are beneficial to me (named patient). I understand that this care may include tests, nursing care, examinations, medical, and surgical treatment.

I authorize Advanced Dermatology of N. Indiana, P.C. to fax records to any physician or pharmacy for the purpose of coordinating and/or managing healthcare.

If patient is a minor: I (parent/guardian) authorize my provider to treat my underage child/dependent, and in the event of an emergency if this child/dependent is not accompanied by a parent/guardian, my provider may provide emergency treatment.

My health care provider may determine it is necessary to perform diagnostic test, medical, and/or surgical procedures judged by him/her as necessary for my (named patient) treatment and advise of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my provider as to the result of any treatments, examinations, and/or operative procedures performed in the provider's office.

I acknowledge I have received a written copy of Advanced Dermatology of Northern Indiana, P.C.'s Notice of Privacy Practices. I acknowledge and will comply with the written copy of Advanced Dermatology of Northern Indiana, P.C.'s financial policy as posted in the waiting room. I acknowledge the practice of Advanced Dermatology of Northern Indiana, P.C. does not participate in Managed Health Services (Medicaid) nor does the practice participate in Tricare.

Release of Medical Information

I hereby authorize the provider involved with my (named patient) care to release information from my (their) medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the providers charges and/or professional fees; to any entities designated by me for discharge and planning purposes, which includes those I listed on the DermacenterMD registration form.

Medicare Consent (If applicable)

I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider or organization furnishing the services or authorize such provider or organization to submit a claim to Medicare for payment to me. The Medicare intermediary advises that the type of services may no longer qualify as covered under Medicare.

Assignment of Benefits/Financial

I hereby assign payment directly to Advanced Dermatology of Northern Indiana, P.C. all insurance benefit payments (including any major medical payments) due to me as a result of the named patient's outpatient treatment or service and pursuant to any insurance contract I have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third party payors.

** I agree co-insurance or deductible amounts are my responsibility. I also acknowledge that the filing of insurance claims is NOT a guarantee of payment, and that I am financially responsible for payment if such claims are unpaid. I understand there is a $25.00 fee for returned checks and any and all collection fees or attorney fees as a result of delinquent payment will be my responsibility.** I understand laboratory and/or pathology fees are associated with some procedures and agree to pay these to the appropriate facilities including outside pathology facilities.

I understand medicine is a service business and not keeping appointments adversely affects medical care. I accept the practice reserves the right to charge $35 for appointments cancelled with less than 24 hours notice or not kept by me (no show).

By signing this document, I acknowledge that I have read and understand this consent. Further, I hereby consent and authorize this facility to use or disclose my Protected Health Information in conjunction with Treatment, Payment or Health Care Operations in accordance with the terms of this consent.

Signature: _____ **Date:** _____

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