



SOUTHLAKE DERMATOLOGY

1170 N. CARROLL AVE. SOUTHLAKE, TX 76092

WWW.SOUTHLAKEDERMATOLOGY.COM

MAIN 817-251-6500 FAX 817-442-0550

Minor Patients, if applicable

I give my permission for Southlake Dermatology to examine and treat _____, my minor child, in your office without me being present. Any procedures require a parent being present. DOB: _____

Parent or guardian name

Parent or guardian signature

Date

MEDIGAP RELEASE

For Medicare patients with supplemental Medigap insurance, a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize to be released to my Medigap carrier any information needed to determine benefits.

Signed (insured person) _____

Date _____

PRACTICE POLICIES:

In order to serve your needs better, we ask that you read our policies and sign below.

1. We request a 24 hour cancellation notice. Failure to call, "no shows," will be charged a \$30 administrative fee that is not billable to insurance. Surgery and cosmetic "no shows" will be charged \$50.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy to request refills.
3. Co-pays and deductibles are due at the time services are rendered.
4. Patients are responsible for verifying insurance coverage.
5. We attempt to make courtesy phone calls to remind you of your appointment but are unable to provide this service at all times. If you do not receive a reminder phone call and miss your appointment, this does not cancel our "no show" policy above.
6. All returned checks will be charged a \$30 administrative fee.
7. If past bills are sent to collections, there will be a surcharge to cover the cost of the collection agency.

PATIENT HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to abide.
- The patient may revoke this authorization in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Authorization.

I acknowledge that I have read the above authorization and have had access to read Southlake Dermatology's full Notice of Privacy Practices:

Printed Name – Patient or Representative

Relationship to patient (if other than pt)

Signature

_____/_____/_____
Date