CONSENT FOR CARE
ASSIGNMENT OF BENEFITS
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name ____ DOB ______________
Last First M.I.

Guardian Name ____ DOB ______________
Last First M.I.

I, the undersigned, consent to the use and disclosure of my protected health information by Advanced Dermatology of Southeast Missouri, P.C. ("Advanced Dermatology") for the purpose of carrying out my treatment, obtaining payment for my health care or for carrying out health care operations.

I understand that I have a right to review Advanced Dermatology's Notice of Privacy Practices prior to signing this document. I hereby acknowledge that I received a copy or was given the opportunity to review Advanced Dermatology's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Advanced Dermatology may use and disclose protected health information about me. A copy of this Notice of Privacy Practices is provided in the waiting area of Advanced Dermatology.

Advanced Dermatology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I acknowledge that I have the right to request that the use of my protected heath information be restricted in carrying out my treatment, obtaining payment for my health care or for carrying out the health care operations. However, I understand that Advanced Dermatology is not obligated to agree to any such restriction. If Advanced Dermatology and I agree upon any restrictions, such restrictions will be in writing and both Advanced Dermatology and I will agree to terminate any such restriction in writing.

My "protected health information" includes all individually identifiable information which is created or received by Advanced Dermatology and which relates to my past, present or future physical or mental health or condition, the provision of health care to me or to the past, present or future payment for the provision of health care to me.

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, Medicare and/or any other health plan to: **Advanced Dermatology of Southeast Missouri, P.C.** for any services furnished me by Advanced Dermatology. I authorize Advanced Dermatology to release any medical information to such private insurance, the Centers for Medicare & Medicaid Services and/or any other health plan to the extent such information is needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the above services are being provided to a minor, the personal representative below agrees that he/she is financially responsible for all charges whether or not paid by said insurance.

I agree that I will pay all collection agency costs and/or reasonable attorney fees if my account is placed in collection. I understand that all applicable co-pays associated with specialty care will be collected on the date of service. I further acknowledge that Advanced Dermatology has a $25 fee for returned checks, and my failure to cancel a follow up appointment within 24 hours prior to the appointment time will result in a $50 fee. Furthermore, my failure to cancel a scheduled surgical appointment within 24 hours prior to the appointment time will result in a $200 fee.

A photocopy or fax copy of this consent and assignment of benefits is to be considered as valid as the original

______________________________ ______________________
Signature of Patient or Personal Representative Date

______________________________ ______________________
Name of Patient or Personal Representative Description of Personal Representative's Authority