SHAH DERMATOLOGY, LLC

ARPANA A. SHAH, MD, FAAD ANGELA CALLANDER, CRNP L. LINDSEY NORTH, CRNP ASHLEY NEEDHAM, CRNP

HIPAA & OFFICE CONSENTS

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include examinations, diagnostic procedures, and treatments. If patient is under the age of 18, I give permission for the patient to receive follow-up care from the physicians and staff at Shah Dermatology, LLC in my absence.

Assignment of Benefits

I authorize my insurance company to make direct payment to the provider of services for the professional or medical expense benefits allowable under my current insurance policy. That is, my insurance company will make direct payment to Shah Dermatology for services rendered rather than to myself.

If I have Medicare/Medigap, I request that the benefits are made directly to Shah Dermatology, LLC for any services furnished me by that physician supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents or any other insurance carrier, any information needed to determine these benefits payable for related services.

Financial Responsibility

I agree to pay all charges for medical or other services not covered by my insurance company. I further understand that I am responsible for all collection and/or attorney fees necessary to collect this debt.

HIPAA Consent

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that governs the use and disclosure of a person's health information. The following statements cover the basics of your rights as a patient under HIPAA.

1. Protected health information may be disclosed for treatment, payment, or health care operations.
2. Shah Dermatology has a Notice of Privacy Practices and the patient has an opportunity to review this notice. To obtain a copy of this notice ask the office staff. Shah Dermatology reserves the right to change the Notice of Privacy Practices.
3. The patient has the right to restrict the uses of his or her protected health information but Shah Dermatology does not have to agree to those restrictions.
4. The patient may revoke this Consent in writing at any time and all future disclosures will then cease,
5. Shah Dermatology may offer or refuse treatment based upon the execution of this consent.

Consent to Photography

I authorize Shah Dermatology, LLC and its agents to use photography to enhance my medical record. My photograph or likeness will be part of the medical record and not used for any educational or promotional purposes or shared with any other third party without my written consent. The use of these photos is strictly for medical record keeping.

Consent to in office Procedures

I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery / electro cautery. I understand that my provider will discuss in detail any procedure he/she plans to perform, answer all questions relating to the procedure and obtain oral informed consent in the exam room

Consent to Obtaining Prior Medical Records

I authorize Shah Dermatology, LLC and its agents to obtain my prior dermatological records from Shah Associates, MD, LLC.

I certify that I have read the six sections above, agree to the above statements.

PRINTED NAME OF PATIENT

NAME (LAST, FIRST, MI)	DATE:
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:	SOCIAL SECURITY NUMBER