Certified Dermatology

Patient Name:

_____Date_____

First MI Last

ACKNOWLEDGEMENT OF THE RECIEPT OF NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION (PHI). WE ARE ALSO REQUIRED TO PROVIDE YOU WITH OUR NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES OUR LEGAL RESPONSIBILITIES AND YOUR RIGHTS REGARDING THE USE OF YOUR PHI. YOUR SIGNATURE BELOW IS AN ACKNOWLEDGEMENT THAT YOU HAVE HAD AMPLE TIME TO READ THE NOTICE (POSTED IN THE WAITING ROOM) AND ASK QUESTIONS REGARDING ITS IMPLEMENTATION. A COPY OF THE PRIVACY PRACTICES IS AVAILABLE UPON REQUEST (PLEASE ASK FRONT DESK STAFF FOR A COPY)

Signature (Patient/ Authorized person) _____ Date_____

Designation of certain relatives, close friends and other caregivers

I agree that Certified Dermatology of New Jersey, LLC may disclose certain elements of my health information to a family member, close personal friend or guardian because such a person is involved with my healthcare. In that case, Certified Dermatology of New Jersey, LLC will disclose only information that is directly relevant to that person's involvement with my healthcare or payment relating to my healthcare. I designate the following person(s) listed below as a person(s) involved in my healthcare or payment related to my healthcare for the purposes of Certified Dermatology of New Jersey , LLC making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at anytime in writing**.**

I agree that my protected health information (PHI) may be shared with the following people:

_____ _____

_____ _____

Signature (Patient/ Authorized person) _____ Date_____

Communication of test results

Preferred method(s) of communication: □ Home phone □ Mobile phone □ Work phone

Is it OK to leave a detailed message on your answering machine? Yes_____ No_____

Information Release

I AUTHORIZE THE RELASE OF MEDICAL INFORMATION TO MY REFERRING PHYSICIAN, TO CONSULTANTS IF NEEDED, AND AS NECESSARY TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CERTIFIED DERMATOLOGY OF NEW JERSEY. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY AMOUNT NOT COVERED BY INSRUANCE. I UNDERSTAND THAT MEDICARE AND MOST INSURANCE COMPANIES DO NOT COVER MEDICAL SERVICES THAT ARE CONSIDERED COSMETIC IN NATURE. THIS INCLUDES BUT IS NOT LIMITED TO PROCEDURES SUCH AS REMOVAL OF SKIN TAGS, UNSIGHTLY BLOOD VESSELS, BOTOX, JUVEDERM, AND RESTYLANE INJECTIONS.

Print Name: _____

Signature: _____ Date: _____