TruDerm

Adult & Pediatric Dermatology & Cosmetic Center

Name: _____ Date of Birth: _____

Release of Information:

I_____, give permission to the staff at TruDerm, PA to leave me a message on my (please check) answering machine ____ on my cell phone ____ with the following person(s):

Name | Relationship and Phone #: _____

Name | Relationship and Phone #: _____

Receipt of HIPPA Policy:

I, _____, acknowledge that I have received the privacy policy for TruDerm, PA (available at the front desk or online at (insert website name)

Cancellation Policy:

We request 24 hours' notice for all canceled appointments. We reserve the right to charge a $35.00 missed appointment fee if you cancel within 24 hours or fail to show for your scheduled appointment time.

Thank you for your consideration in this matter.

Patient/Representative Signature: _____ Date: _____

Medicare Patients Only:

Our practice is a participating provider with Medicare. We accept assignment on all claims. Patients are responsible for their annual deductible and the 20% portion of your bill not covered by Medicare. Our office is required to keep your signature on file authorizing us to file claims to Medicare on your behalf.

Please read and attest to the following statement:

I authorize the release of my medical and/or other information to the Social Security Administration and Health Care Financing Administration needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient/Representative Signature: _____ Date: _____