

SIGNATURE PAGE

PRIVACY PRACTICES (HIPPA):

- By signing I give DLDM authorization to use and disclose PROTECTED HEALTH INFORMATION about me to carry out Treatment, Payment, and healthcare Operations (TPO). Please refer to DLDM's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DLDM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the DLDM office manager.

- By signing I authorize DLDM and their staff to leave/mail information that will assist the practice in carrying out TPO, such as appointment reminders, insurance items, and biopsy results. I assume responsibility to notify DLDM whenever this information changes.

Contact me and/or leave a detailed message at (check all that applies):

- Home: _____
- Work: _____
- Mobile: _____

Please list any persons to whom your protected health information can be disclosed to (e.g. parents, spouse, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- By signing I authorize the release of medical information to my primary care/referring physician, pathology, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to Dr. Deborah Atkin/DLDM. I understand that if my insurance does not pay in full, that I will be financially responsible for co-payments, co-insurance, deductibles, and non-covered services. I understand that DLDM will NOT bill insurance for any cosmetic services.
- If the physician needs a second opinion on the tissue removed during biopsy in order to make a final diagnosis of the condition, I accept responsibility for the payment of the specialist who makes the diagnosis. I understand that I will receive separate billing from the specialist (dermatopathologist).

My signature below acknowledges that I have read, understand, and agree to ALL of the above DLDM Policies.

Print Patient's Name

Patient's Signature

Date

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