Release and Authorization Patient Name:_______________________________ DOB______________

If you would like for us to be able to discuss your medical care with a family member or caregiver, please list their name/ names here (you must list spouse/parent name here in order for information to be released): ____

****parents, please list names of each parent/guardian that we may release medical information to above as well****

Assignment of Benefits

I hereby authorize payment directly to Triangle Dermatology Associates by my insurance company.

Release of Information

I authorize the release of medical information to my primary care or referring physician, to consultants when necessary and as necessary to process insurance claims, and obtain prescriptions.

Patient Consent for Use and Disclosure of Health Information

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices dated 9/1/13.

Financial Policy

I hereby acknowledge that I have received a copy of Triangle Dermatology's Financial Policy and I understand and agree to abide by it.

Patient/Guardian Name(please print):____

Signature:____________________________________ Date:__________________________

MEDICARE PATIENTS ALSO NEED TO READ AND SIGN BELOW :

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid Services or its intermediaries or carrier any information 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.

Signature as it appears on Medicare card:_________________________________

MEDIGAP:

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically crosses over, we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the indicated carrier any information needed to determine these benefits payable for related services.

Signature as it appears on MEDIGAP Card:____

MINORS: If the patient is an unaccompanied minor, please fill out the following consent for treatment

I give my consent for my son/daughter_____________________________ to bring himself/herself to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's name (Please Print)_______________________________________

Parent's signature____

Date: ____