Pediatric Dermatology
of North Texas

CONSENT

Last Name	First Name	D.O.B

Pediatric Dermatology of North Texas, PA (PDNT) and its providers are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area and on our website www.pediatricderm.com. You are not required to read this notice, however, we would like your acknowledgement that you have been advised that PDNT has such a Notice of Privacy Practices.

Also available on our website for you to review and/or print is our office policy, no show policy and HIPAA notice.

Medical Benefits:
I hereby assign, transfer and set over to PDNT all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I appoint PDNT to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery. All charges are due at the time of service.

I give my permission for the doctor to administer and perform care for myself or my minor child as needed based upon the information on which I provide.

Patient/Guardian Signature	Date