Advanced Dermatology of Westchester, PLLC
150 White Plains Rd., Suite 210
Tarrytown, New York 10591
(914) 631-4666

PATIENT ACKNOWLEDGEMENT AND CONSENT

Patient Name:_____Date of Birth:___/___/___
Last *First* *Middle Initial*

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. The Notice of Privacy Practices contains a Patient Rights section describing your rights under the law. By signing this form, you acknowledge and consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

Our **Operational and Financial Policy** provides information about appointments, insurance requirements and general financialguidelines. By signing this form, you understand and agree to your financial obligations as stated in this policy.

You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

This consent was signed by: _____
Print Name – Patient or Representative/Responsible party

_____ Date:___/___/___
Signature

_____
Relationship to Patient if Representative/Responsible party

Medicare Insured ONLY, This office is required to keep your signature on file authorizing us to file claims to Medicare. Please read the following statement: *I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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.*

Patient signature as it appears on Medicare card:_____ Date: ___/___/___