MADRONA DERMATOLOGY

PATIENT AGREEMENT

RELEASE OF INFORMATION: _____ (Your Initials)

I authorize the release of medical information to my primary care physician, referring physician and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: _____ (Your Initials)

I have received and/or reviewed a copy of Madrona Dermatology's Notice of Privacy Practices.

CANCELATION POLICY: _____ (Your Initials)

I am aware that there will be a fee of $50 for appointments that are missed, cancelled or rescheduled without 24 hour notice and that if I miss three appointments, I may be moved to walk-in status.

MESSAGES / FOLLOW-UP COMMUNICATIONS: _____ (Your Initials)

Do we have your permission to:

Leave a message on your home or cell phone? (Circle one/both) ___ Yes __ No
Leave a message at your place of employment? __ Yes __ No
Discuss your medical condition with a person other than yourself? __ Yes __ No

If YES, whom: _____ Relationship: _____

MEDICARE PATIENTS ONLY:

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 payor if they require it for the proper consideration of a claim. PLEASE READ AND INITIAL 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. _____ **(Your Initials)**

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", PLEASE READ AND INITIAL THE FOLLOWING STATEMENT

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 above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ **(Your Initials)**

_____ _____
Name of Patient *Name of Responsible Party*

_____ _____
Signature of Patient or Responsible Party *Date*

FOR OFFICE USE ONLY IF PATIENT REFUSES TO SIGN: I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

☐ Patient Refused to sign ☐ Communications barriers ☐ Emergency situation ☐ Other (explain)

Office Employee Signature:_____ Date:_____