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RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of Red River Dermatology's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

_____ _____
Signature Patient/Guardian Date

ASSIGNMENT OF BENEFITS

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Red River Dermatology. I authorize Red River Dermatology to provide to my insurance company, any information necessary to process claims for services rendered to me.

_____ _____
Signature Date

MEDICARE ONLY

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.

_____ _____
Signature as it appears on Medicare Card Date

MEDIGAP (MEDICARE ONLY)

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 paid on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature as it appears on MEDIGAP Card Date

MISC CONSENTS: (PLEASE CIRCLE Y or N)

PHOTOGRAPHIC CONSENT:

In certain instances, the physician or her assistants may take photographs for use in your personal medical record only (ie, for the purposes of establishing a baseline prior to therapy, to document response to therapy, or to document a biopsy site). Do you consent to this? **Y** **N**

PERMISSION TO CONTACT YOU:

May we send postcards to your address above with promotional information? **Y** **N**
May we leave a message on your home answering machine? **Y** **N**
May we leave a message for you at work to call us? **Y** **N**

PERMISSION TO DISCUSS YOUR CONDITION WITH A FRIEND OR FAMILY MEMBER:

May we discuss your medical condition with another person? **Y** **N**

If yes, whom_____ Relationship:_____ Phone: _____

_____ _____ _____
Patient or Guardian Name Signature Date