HIPAA & Financial Consent Receipt of Notice

I am a patient, or parent/legal guardian of the patient listed below, of Sheftel & Associates Dermatology, LLP (dba HealthySkin Medical & Cosmetic Dermatology). By giving my signature below, I hereby acknowledge receipt of HealthySkin Medical & Cosmetic Dermatology's *Notice of Privacy Practices & HIPAA Consent* and *Financial Consent*.

I give consent for all my protected health information (PHI) to be shared with:

_____ _____

Full name Relationship

_____ _____

Full name Relationship

By acknowledgement of receipts of the *Financial Consent*, I hereby authorize direct payment of surgical/medical benefits to HealthySkin Medical & Cosmetic Dermatology for services rendered by any providers of such group. The patient agrees to pay for all medical services not paid by insurance coverage.

_____ _____

Name of patient Date of birth

_____ _____

Signature of patient or personal representative Date