HIPAA & Financial Consent Patient/Parent/Legal Guardian 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). I hereby acknowledge receipt of HealthySkin Medical & Cosmetic Dermatology's Notice of Privacy Practices (Privacy Practices & HIPAA Consent, V2 05.15.2015) and Financial Consent (Financial Consent V2 05.15.2015).

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

_____ Relationship: _____

_____ Relationship: _____

By acknowledgement of receipt 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. Patient agrees to pay for all medical services not paid by insurance coverage.

_____ _____

Name of Patient DOB

_____ _____

Signature of Patient or Personal Representative Date