BARBA
DERMATOLOGY

Consent for Treatment
Insurance Release/ Authorization

Please read and sign below:

I authorize Barba Dermatology to take photographs of me to demonstrate surgery/ cosmetic procedure(s)/ biopsy sites. Photos will be filed in my private chart and not be shared without my written consent. All cosmetic procedures require before and after photographs filed in my electronic medical record. This is non-negotiable.

I authorize that the payment of insurance benefits be made on my behalf to Alicia Barba MD PA for all services provided to me. Prior to disbursing payment for services, my insurance company may require documentation from my medical record in order to process claim and approve payment. I understand that it is my responsibility to provide the insurance company any information requested from me, by them, quickly. Not doing so can delay payment to Barba Dermatology.

I understand **I may be billed by an outside laboratory** for blood work and any specimen(s) sent to a laboratory for biopsy, examination or culture. Almost all human tissue is sent to be analyzed by an outside lab when it is removed for proper diagnosis and documentation. All blood work and pathology is first billed by outside labs to your insurance. If you have a deductible, these services will be billed to you by the outside labs as part of your deductible. Please note that this charge is independent of any service done by us in our office.

A "visit or consult" is the fee charged to consult or speak with the doctor. A "procedure or surgical fee" is a separate fee charged any time the skin or a lesion is squeezed, popped, drained, removed, biopsied, injected, frozen, scraped, drained, lasered, cauterized or burned. The "procedure" fee is always separate from the "visit" and is billed to you or your insurance as two separate fees.

I understand that insurance may not cover certain procedures and/or medications. (Our staff is very sensitive to this and when possible will try to warn you however, we cannot change the rules of your insurance policy). I further understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments. I agree to assume full responsibility for the balance not covered with the EASY PAY FORM. I hereby authorize the providers of Barba Dermatology Group to examine and treat me.

____________________________________ ____________
Signature of Patient (or Parent if Minor) Date

Patient Consent for Use and Disclosure of Protected Health Information: HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. **You have the right to review our Notice before signing this Consent. A copy is available at the front desk.** The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge that you received our Notice of Privacy Practices and you consent to our use and disclosure of protected health information about you for treatment, payment from your insurance company and health care operations. 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. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. It is located on our website: Our Practice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

I hereby authorize Alicia Barba MD PA and Staff to share my Protected Health Information with the following person(s): List parents, spouses or partners you want to have access here

please list anyone that is allowed to have information about your medical care in this box

____________________________________ ____________
Signature of Patient (or Parent if Minor) Date