# HIPAA Authorization

I authorize Water's Edge Dermatology and its agents to disclose my protected health information and compliance information among Water's Edge Dermatology, its agents and/or myself for the purpose of my care and treatment. I further authorize Water's Edge Dermatology to disclose my protected health information, including copies of applicable hospital and medical records and protected health information obtained prior to the date of this authorization to:

- Any third-party payer covering the medical services of the patient;
- Other health care professionals and institutions involved in the delivery of health care to the patient;
- The proponent of any legally sufficient subpoena, or in response to a court order;
- Employees, and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body to be used for medical records. In each case, Water's Edge Dermatology shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I also hereby authorize the disclosure of personal health information to persons that I choose to accompany me in the office while examined.

Water's Edge Dermatology may contact me to remind me of my appointment or collect money that I owe to Water's Edge via telephone, text message or email at any number or email given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that such communication may come by autodialing devices and through pre-recorded messages, artificial voice messages or voicemail messages.

In granting this authorization, I understand that:

1. The term "protected health information" includes information obtained through self-reported symptoms, testing and treatment of and for dermatological issues.

2. I have been given access to Water's Edge Dermatology Privacy Notice.

3. I have had the opportunity to place special restrictions upon the consent hereby given.

4. I have the right to revoke this authorization at any time by writing to Water's Edge Dermatology at 600 Village Square Crossing, Palm Beach Gardens, FL., 33410

5. I may revoke this authorization except to the extent that information has already been disclosed based on this authorization.

6. Signing this authorization is voluntary. I agree that treatment at Water's Edge Dermatology may be denied if I do not authorize this release of protected health information.

7. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**I also hereby authorize the disclosure of personal health information in the following manners and to the following persons:**

Initial if okay to leave a message on voicemail: _____

E-Mail to the following address: _____

To the following individuals (include individual's name and birthday for verification purpose):

1. Name _____ D.O.B. _____
2. Name _____ D.O.B. _____
3. Name _____ D.O.B. _____

Special Restrictions:

This executed authorization will be stored by Water's Edge Dermatology and will be available to you upon request. A copy of this authorization is as valid as the original.

This authorization does not have an expiration date.

_____ _____

Patient signature Date

INSURANCE RELEASE:

*I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Water's Edge Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.*

**YOUR INSURANCE POLICY**

Due to the many changes in insurance policies, we are unable to interpret the benefits of each individual policy. It is your responsibility to know your individual coverage and its limitations as well as who is a provider for your plan. We urge you to contact your insurance company and verify your benefits because failure to do so could result in you, the patient or financially responsible party, being held responsible for all costs incurred.

**REFERRALS**

If your policy requires a referral from your Primary Care Physician to be seen in this office, the referral must be present at the time of visit. We will make every attempt to secure one on your behalf but ultimately the responsibility is yours. Without one, you may be required to reschedule your appointment. We welcome you to call your PCP and have your referral faxed to us. **NON-PARTICIPATING PROVIDER POLICY**

If we are not an in-network provider with your insurance company, we will collect our fees in full at the time of service.

**LABORATORY SERVICES**

You may incur additional charges from providers outside of your network for procedures done outside of our facility that may be part of your surgical procedure or exam. This can include pathology, radiology and/or lab fees.

FINANCIAL STATEMENT:

Payment is required for all services at the time they are rendered unless you are covered by an insurance plan in which Water's Edge Dermatology participates. For those patients covered by an insurance plan in which we participate, applicable co-payments, coinsurance and deductibles will be collected at the time of service. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, a collection fee up to 35% will be added to the account.

MEDICAL RECORDS RELEASE:

I hereby authorize Water's Edge Dermatology to obtain medical records, x-rays, lab results, scans from: Referring, Family or Primary Physician _____

I agree and acknowledge the above medical records, insurance and financial statements.

_____ _____

Signature of Patient/Responsible Party Today's Date