

SOUTHWEST DERMATOLOGY

15300 WEST AVENUE S120

ORLAND PARK, IL 60462

(708) 460-7890

HIPAA

Southwest Dermatology understands the importance of keeping your personal and health information private. We are required by state and federal law to adhere to these guidelines.

Below you will find a condensed version of your rights as a patient, and our rights as a practice. For a more detailed explanation of the HIPAA law, our office has a copy for your convenience.

Both under law, and our policy, we:

- Protect your privacy by limiting who may see your PHI (private health information)
- Limit how we may use or disclose your PHI
- Inform you of our legal duties with respect to your PHI
- Explain our privacy policies

Southwest Dermatology may disclose your personal / health information for:

- Treatment / Payment
- Overseeing your health care operations regarding evaluation and clinical outcome
- As required by law, i.e., court summons
- Insurance

Your rights as a patient:

- You have a right to review your medical records
- You have a right to request copies of your medical records. You must sign a written authorization notifying our practice of release of information. We have the right to charge you a copy fee.
- You have the right to know to whom we are giving medical information.
- You have the right to request that we not release any information without your approval.
- You have the right to request that we amend your medical information. It must be in writing, and you must explain why the information should be amended.

This is a summary of the HIPAA law. Our office can amend this policy at anytime. We would like you to sign this disclosure, knowing you have read and understood the contents. The detailed version is available upon request by this office. This agreement will only change upon patient's request and signature.

Signed _____
Patient / Guardian Signature (relationship)

Date: _____

I give my permission to Southwest Dermatology to release any medical information to:

Name _____

(relationship) _____

Signed: _____

Date: _____

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ASSIGNMENT AND RELEASE

Name of Patient: _____

Date: _____

Name(s) of Insurance Carrier(s): _____

I, the undersigned, have insurance coverage and assign directly to **SOUTHWEST DERMATOLOGY**, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorized Southwest Dermatology to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **SOUTHWEST DERMATOLOGY** for any services furnished me by Southwest Dermatology. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 FORM, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

PATIENT RESPONSIBILITY FOR CLAIMS

My signature below acknowledges that the office of Southwest Dermatology will file claims to my Insurance Carrier. I understand that I am responsible for the entire, unpaid balance, for services that have been provided to me.

Signature of Patient

Date

If patient is a minor, Parent, or Representative

Date

Relationship to Patient