NorCal Dermatology

Medical | Surgical | Cosmetic

Consent for treatment: I give NorCal Dermatology and Cosmetic permission to evaluate and treat my condition(s).

Payment for services: I understand that I am responsible for fees my insurance does not pay toward my claim, including co-payments, deductibles, and services that my insurance considers cosmetic or not medically necessary. I authorize payments be made by my insurance company to NorCal Dermatology and Cosmetic on my behalf.

Release of Information: I authorize release of information to my primary care or referring physician as necessary to provide or coordinate care. I also authorize release of information to my insurance company for claims processing.

Treatment of Minor: I give permission for my child (under **18**) _____ to be treated by NorCal Dermatology and Cosmetic, Khanh Truong, MD or Henry DeGroot, MD. If I am not able to accompany my child to a follow-up appointment, I give permission for my child to be treated in my absence.

Parent/ Guardian _____ DOB _____ Date _____

NOTICE OF PRIVACY PRACTICES CONSENT FORM:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protested health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be in involved in that treatment directly and indirectly.
- Obtain payment from third party-payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your 'Notice of Privacy Practices' containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such 'Notice of Privacy Practices' prior to signing this consent. I understand that this organization has the right to change its 'Notice of Privacy Practices' from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the 'Notice of Privacy Practices'. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out the treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

Patient Name _____ DOB _____

Signature _____ Date _____

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