DERMATOLOGY ASSOCIATES OF YORK, INC.

AUTHORIZATION & CONSENT

PATIENT:_____ ACCOUNT:#_____

I am requesting medical services, including but not limited to: evaluation, examination, diagnosis and treatment, from providers at Dermatology Associates of York, Inc.

I understand the following:

- Services are provided by physicians, physician assistants, nurses, and other employees of Dermatology Associates of York, Inc. and;
- At times, Dermatology Associates of York, Inc. participates in teaching other medical personnel. A provider may be assisted or accompanied by resident physicians, Fellows, or other students engaged in medically related training and education. If I object to the presence of such personnel, I will advise my provider.

I authorize Dermatology Associates of York, Inc. staff to perform diagnostic and/or therapeutic procedures as may be deemed necessary by my attending provider or other authorized health care professional of Dermatology Associates of York, Inc.

I understand that no guarantee or assurance has been made to me as to the results of any care or treatment that is provided.

I have been provided the opportunity to ask questions concerning the information contained in this authorization and consent. By signing below, I express my understanding and agreement.

_____ _____

Signature of Patient or Authorized Representative Date

Printed Name of Patient or Authorized Representative:_____

Relationship of Authorized Representative: _____

DERMATOLOGY ASSOCIATES OF YORK, INC.
FINANCIAL AGREEMENT / ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT:_____ ACCOUNT:#_____

Financial Agreement

I understand that be receiving evaluation, care, and treatment from Dermatology Associates of York, Inc., I am fully responsible for payment of all applicable charges and expenses to the extent they are not fully reimbursed directly to the practice by a third party payor.

In the event that it becomes necessary for the practice to engage the services of a collection agency or attorney for the collection of any balance that I owe to Dermatology Associates of York, Inc., I understand and agree that I will be responsible for all reasonable fees and costs charged to Dermatology Associates of York, Inc. by such agency or attorney.

By my signature below, I understand, and accept financial responsibility as set forth in the paragraphs above.

Patient Signature:_____ **Date**:_____

IF FINANCIAL RESPONSIBILITY IS ACCEPTED BY ANOTHER PARTY:

By my signature below, I understand, agree, and accept financial responsibility as set forth in the paragraphs above on behalf of the patient identified above.

Signature:_____ **Date**:_____

Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Dermatology Associates of York.

Patient Signature:_____ **Date**:_____

OR

Patient's personal representative with legal authority to make health care decisions on the patient's behalf.

_____ _____

Personal Representative's **Printed Name** Relationship to Patient

Personal Representative's **Signature**: _____Date:_____

OFFICE USE ONLY:

If The Acknowledgement of Receipt of Notice of Privacy Practices is not signed by the patient, or representative with legal authority to make health care decisions on behalf of the patient, complete the following:

The Notice of Privacy Practices was given to the patient or their personal representative on _____
by_____.
The following good faith efforts were made to obtain the signature of the patient, or personal representative:
_____
_____

Reason Patient or Personal Representative did not sign the acknowledgement:

- ☐ Patient/personal representative refused to sign
- ☐ An emergency situation prevented obtaining acknowledgement
- ☐ Other (Please specify) _____

Signature:_____ **Date**:_____