



ALICIA BARBA, M.D, P.A.

Consent for Treatment

Insurance Release/ Authorization

Please read and sign below:

I hereby authorize Dr. Alicia Barba to examine and treat me, including any biopsy or procedure(s), as deemed necessary to provide dermatologic care and aid in the diagnosis of my skin disorder. I understand that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that a scar can result from any procedure and the type or severity of such scarring cannot always be predicted before the procedure.

I authorize Dr. Alicia Barba to take photographs of me for my medical record and for educational purposes. I understand that the photographs may include appropriate portions of the body to demonstrate surgery/procedure(s) and that every effort will be made to protect my identity in those materials.

I do not give authorization for photographs to be taken of me: _____
initials

I authorize that the payment of insurance benefits be made on my behalf to Alicia Barba MD PA for any services furnished to me. I further understand that 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 my insurance may not cover certain procedures and/or medications. (Dr. Barba is very sensitive to this and when possible will try to warn you however, she 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. See **EASY PAY FORM.**

I understand I may be billed **by an outside laboratory** for work that is performed in this office either because my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

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
- 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): _____

(please list anyone that is allowed to have information about your medical care)

Signature of Patient (or Parent if Minor)

Date