Wilson Dermatology & Skin Care

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Langhorne, PA 19047
Phone: (215) 486-8272 Fax: (215) 757-3600
www.wilsonderm.com

HIPAA Privacy Receipt of Privacy Practices Acknowledgement

I understand that as part of my health care, Wilson Dermatology & Skin Care originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided (master copy posted in waiting area) with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review the facility's Notice of Privacy Practices prior to signing this acknowledgment.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

_____ _____
Printed Name of Patient/Legal Representative Relationship to Patient

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

As a patient of Wilson Dermatology & Skin Care, from time to time we may need to communicate with you. To preserve your privacy, please indicate your preferred method for us to communicate medical l information to you. Examples of information include test results, appointment reminders and other information of a clinical nature.

Please check one:

____ *DO NOT leave any medical information on my answering machine or voice mail.*

____ *I give permission to Wilson Dermatology & Skin Care to leave medical information on my answering machine or voice mail.*

You may also designate two additional people with whom we may discuss your medical information with.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Financial Assignment and Release:

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for all non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

_____ Date: _____/_____/_____
Signature