FINANCIAL LIABILITY STATEMENT AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that I am personally financially responsible for charges incurred for services rendered by Rao Dermatology if any of the following apply:

1. My health benefit plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Rao Dermatology and I have not obtained such authorization or referral or I receive services in excess of such authorization or referral.

and/or

2. My health plan determines that the services I receive at Rao Dermatology are not medically necessary.

and/or

3. My health plan coverage has lapsed or expired at the time I receive services at Rao Dermatology.

and/or

4. My health plan is not one that Rao Dermatology participates in.

and/or

5. I have chosen not to use my health plan coverage

I also understand that I am responsible for all co-payments and co-insurance charges under my health plan.

Please advise us of your correct insurance carrier and provide us with your current, up-to-date insurance coverage information. Negligence to do so will result in the assessment of a $50 reprocessing fee.

Medicare Patients: I hereby authorize direct payment of surgical/medical benefits to Doctor Rao for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Records Release: I authorize the release of my prior medical records, if needed to Rao Dermatology.

I hereby give my consent for Rao Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (Rao Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Rao Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rao Dermatology's Privacy Officer at 345 East 37th Street, Suite 317, New York, NY 10016.

With this consent, Rao Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist in the practice of carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Rao Dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Rao Dermatology may email my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Rao Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Rao Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Rao Dermatology may decline to provide treatment to me.

_____	_____	_____
Print Patient Name	*Patient Signature*	*Date*
_____	_____	
Print Legal Guardian or Guarantor's name	*Signature of Guarantor or Legal Guardian*	