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HIPAA and FINANCIAL POLICY

1) I have reviewed the Dermatology Associates of Rochester, PC privacy notice, Bill of Rights, Patient Insurance, Financial Policy Agreement, and "Surprise Bill" Amendment and I authorize the practice to share my Protected Health Information (PHI) with agencies or individuals that require access to provide necessary medical care. My signature below under either "Witness" or "Patient" indicates I am the authorized user of this insurance information.

2) The name of the person(s) located above the text "DAR - HIPAA" accurately reflects my personal selection of who I authorize DAR to use, share and disclose my PHI to, unless otherwise noted above. My signature below under either "Witness" or "Patient" indicates I have selected said person(s) as of the date of signing. Failure to sign on either line below reflects my decision to disallow disclosure of my PHI to any person(s).

3) Dermatology Associates of Rochester has vetted and selected Muhlbauer Dermatopathology Laboratory (MDL) as our preferred diagnostic facility for their level of expertise and quality of results. I, the undersigned understand that there is a chance MDL could be "out-of-network," and elect to accept any financial charges incurred as a result of being "out-of-network." I acknowledge that I reserve the right to request my pathology specimens be sent to a laboratory considered "in-network," but will notify my provider of this preference prior to the specimen being sent from the office.

4) I have been informed that failure to pay any patient responsibility may result in additional 'collection' fees on top of the balance due which I accept responsibility for in total.