ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY
1220 Avenue P Brooklyn, NY 11229
718-375-7546 (Tel) 718-376-6475 (Fax)

CONSENT FOR OUTPATIENT TREATMENT

AUTHORIZATION

- I hereby authorize Advanced Dermatology Laser & Cosmetic Surgery, the physicians and other healthcare professionals to provide such medical care and to administer such treatment, including immunization as deemed necessary or advisable to me or the named patient every time I or the named patient present to an ambulatory care service. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

- I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

- I authorize any holder of medical or other information about me to release the Social Security Administration and/or its intermediaries or carriers any information needed for this or a related claim.
- I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

GUARANTEE OF ACCOUNT

- For and in consideration of service(s) rendered to_____(Patient Name) by Advanced Dermatology Laser & Cosmetic Surgery.
  I hereby agree to pay for procedures that may possibly be denied by my insurance carrier.
  I have been instructed beforehand of this possibility and I am in compliance with this policy.
  After my primary insurance pays, I agree to pay the balance if my secondary insurance (coinsurance) fails to meet its responsibility.

RELEASE OF INFORMATION

- I permit Advanced Dermatology Laser & Cosmetic Surgery to use and disclose protected health information (PHI) for the purposes of treatment, payment, and healthcare operations, including quality assessment and measurement, and disease management activities.

ASSIGNMENT OF BENEFITS

- **For Medicare patients only:** I request that payment of authorized Medicare benefits be made to me or on my behalf to Advanced Dermatology Laser & Cosmetic Surgery for services furnished to me by the provider. I authorize any holder of medical information about me to release it to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
  Patient Signature_____Date Apr 10, 2014

- I assign to Advanced Dermatology Laser & Cosmetic Surgery all benefits from all corporation agencies and person for these services.
  Additionally, I authorize payment of these benefits directly to Advanced Dermatology Laser & Cosmetic Surgery.
- I confirm that I have read and fully understood the above.

Patient/Relative or Guardian*: _____ _____ Apr 10,2014
Signature Print Name Date

Relationship (if signed by the person other than patient: _____

Interpreter (if required): _____ _____
Signature Print Name

Witness: _____ _____ Apr 10, 2014
Signature Print Name Date

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