

Iowa City Dermatology LLC

269 N 1st Ave Ste 100
Iowa City, IA 52245

ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Iowa City Dermatology LLC and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Iowa City Dermatology LLC of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Iowa City Dermatology LLC and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Iowa City Dermatology LLC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Iowa City Dermatology LLC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Iowa City Dermatology LLC, and will constitute a continuing authorization, maintained on file with Iowa City Dermatology LLC, which will authorize and allow for direct payment to Iowa City Dermatology LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Iowa City Dermatology LLC.

HIPAA PATIENT CONSENT FORM

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. 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 consent to our use and disclosure of protected health information about you for treatment, payment 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 (HIPAA).

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 Practices
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 receipt of treatment upon the execution of this Consent.

Patient/ Insured Signature

Date