PALO DURO
DERMATOLOGY

Patient Last Name: First: Middle:

Patient Date of Birth:

Notice of Privacy Practices Acknowledgement

I hereby acknowledge that on _____(date), I received or was offered a copy of the Notice of Privacy Practices of Palo Duro Dermatology, PLLC which sets forth the ways in which my health information may be used or disclosed by Palo Duro Dermatology, PLLC and outlines my rights with respect to such information.

Signature of Patient or Patient's Representative

Date Completed & Signed

Patient Financial Policy Acknowledgement

I hereby acknowledge that on _____(date), I received or was offered a copy of the Patient Financial Policy of Palo Duro Dermatology, PLLC which sets forth the financial policies of Palo Duro Dermatology, PLLC.

Signature of Patient or Patient's Representative

Date Completed & Signed

Assignment of Benefits

I hereby acknowledge financial responsibility for all fees. I understand that the billing office will file my insurance claim if my physician is a participating provider with my insurance carrier and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I understand that I am responsible for and will pay my portion of the unpaid balance due for services performed by Palo Duro Dermatology, PLLC and Larry Roberts MD.

Signature of Patient or Patient's Representative

Date Completed & Signed