Privacy Acknowledgement and Restrictions

This form is provided to you at registration and subsequently annually. By signing this form, you acknowledge that you have reviewed the Notice of Practices* prior to any services being provided to you by Dermatology of North Texas and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated on the this Acknowledgement and Restriction form.

*A copy of the Notice of Practices is available at the front desk of our clinic.

***We will not release medical information to anyone who is not directly involved in your healthcare without your consent**

RESTRICTIONS: Please list anyone who does NOT have access to you healthcare information. If there are no restrictions, write N/A.

*_____

PERMISSION: Please list anyone whom we may inform about your healthcare:

*_____

If you would like to receive calls regarding your healthcare at a number other than your home number, please list the number and individual to contact here: _____

*Please know that cell phones are not private and secure lines.

"By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me by my healthcare provider and/or the third-party system."

We ask for 24 notice to cancel or move an appointment. Without sufficient notice, you may be charged up to $25 for an office visit and $100 for a surgery that will NOT be covered by your insurance.

*Patient Name:_____ Date of Birth: _____

Signature/Legal Representative:_____

Today's Date:_____ Relationship to Patient (if applicable):_____