GERMAIN
DERMATOLOGY

Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Germain Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Germain Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Germain Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Germain Dermatology at 612 Seacoast Parkway, Mount Pleasant, South Carolina, 29464.

With this consent, Germain Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Germain Dermatology, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Germain Dermatology, may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Germain Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Germain Dermatology's use and disclosures of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Germain Dermatology may decline to provide treatment to me.

_____ _____

Print Name of Patient or Legal Guardian | Date of Birth

_____ _____

Signature of Patient or Legal Guardian | Date

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Please Initial:

_____ I understand and agree to the terms of Germain Dermatology's Photo, Financial, Late Policy & Pathology Policy.

Consent to Share Information

I authorize Germain Dermatology to disclose medical information pertaining to payments, insurance, diagnosis, and my personal health to the following persons:

	Name	Relationship to Patient	Phone Number	Leave a Message
(Primary)	_____	_____	_____	☐Yes ☐No
(Other)	_____	_____	_____	☐Yes ☐No

*The above will stay in effect until voided by you.

Prescription History Consent

Germain Dermatology is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using in order to provide the best possible treatment. By signing this consent form, you are agreeing that Germain Dermatology may request and use your prescription history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Germain Dermatology enroll me in the ePrescribe program.

_____
Signature of Patient or Legal Guardian

Are you covered by any other insurance that makes Medicare secondary? ☐Yes ☐No

If Medicare is your secondary insurance, please circle the type of coverage you have:

1. Working Aged/Spouse Group Plan
2. ESRD
3. No Fault/Auto Primary
4. Worker's Comp
5. Public Health Service/ Other Fed Agency
6. Veteran's Admin
7. Disabled
8. Beneficiary Under age 65
9. Other Liability Ins is Primary
10. Black Lung

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?

☐Yes ☐No

_____
Print Name of Patient or Legal Guardian

_____
Date of Birth of Patient

_____
Signature of Patient or Legal Guardian

_____
Date