ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to Dr. Busch all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

X_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Busch for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved Claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X_____ _____
Signature of Insured/Guardian Date

FINANCIAL AGREEMENT

In case of default of payment, and if this account should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, cost, and other expenses will be paid by the undersigned.

X_____ _____
Signature of Insured/Guardian Date

TREATMENT AUTHORIZATION

I give Forrest Kenton Busch, D.O. authorization to treat myself or my child.

X_____ _____
Signature of Insured/Guardian Date

DYERSBURG SKIN CLINIC

DR. KENTON BUSCH

1150 Highway 51, By Pass West
Dyersburg, TN 38024
(901) 286-4300

NOTICE – INSURANCE CLAIMS

We file insurance claims as a courtesy to our patients, but we expect to be paid in a timely manner. If your claim is not paid within 90 days, you will be expected to pay the balance for the date of visit concerned.

If any incorrect information is given to us & your claim is denied, you will be expected to make full payment. It is your duty to provide full and correct information to this office and the insurance carrier (many times they seek additional information from the patients and hold their claims hostage until they get it).

Claim denials seem to be increasing steadily and neither we, nor you can assume that they will be processed timely or fairly. Therefore, we do not assume the risk that the claim will be approved. We will work with you to be certain that we have done everything properly to help you receive your benefits. However, if the claim is not paid within 90days we expect payment. We can continue to help you obtain re-imbursement if proper.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING MY BILL IN FULL AFTR 90 DAYS IF MY INSURANCE HAS FAILED TO DO SO.

NAME _____ DATE _____

PATIENT CONSENT FORM

Dyersburg Skin Clinic
1950 Street
Dyersburg, TN 38024

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosure of healthcare information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name_____ Signature_____ Date_____

Please initial only one of the options below.

_____ Yes, I would like a copy of the Notice of Privacy Practices form.
Initials

_____ No, I do not want a copy of the Notice of Privacy Practices form.
Initials