VILLA DERMATOLOGY CENTER, LLC
(305) 857-3517
WWW.VILLADERMATOLOGY.COM

CONSENT AND ACKNOWLEDGEMENT FORM

	ASSIGNMENT OF INSURANCE BENEFITS
________ Initial	I authorize payment of Medicare or other insurance benefits otherwise payable to me for medical service rendered to me or my child directly to ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC. These benefits are not limited to Individual Policies, Group Policies, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits. Where MEDICARE BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC on my behalf.

	THIRD PARTY BENEFIT COLLECTIONS
________ Initial	I authorize ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC, to act in my behalf as attorney in fact in The collection of benefits from any responsible third party payer through whatever means may be deemed necessary, and the endorsement of benefit checks made payable to me and/or ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC or any of its providers.

	GUARRANTEE OF PAYMENT
________ Initial	I hereby understand that I am financially responsible for payment to for any charges not covered or allowable by my Insurance Company, and all deductibles, co-insurance, co-payments, and for any balances remaining, after payment has been made by my Insurance Company. This includes any denials of payment due to lack of medical necessity or pre-certification/authorization, lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collection, I will be responsible for applying the balance owed to the physician plus the cost of the collection fees, and/or including reasonable attorney's fees if/when applicable. For patients with no insurance coverage, payment is due at the time of service. We accept cash, checks, and major credit cards. Returned checks are subject to a $50 fee. For patients who have insurance coverage with a plan in which we are not participating providers, you are required to play 50% of the balance at the time of service and we will bill your insurance showing your payment. The insurance will then let us and you now if there is a remaining balance, for which at that time you will be billed. Payment, must be made to our office by you accordingly. It is the responsibility of the patient to notify our office if there is any change in your mailing address, contact information or health insurance.

	CONSENT TO TREATMENT
________ Initial	I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, anesthesia, laboratory procedures and medications that may be performed, administered or rendered by or under specific or general instructions of my physician. I hereby voluntarily consent to rendering of medical treatment by ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC and or medical staff, which may include routine diagnostic and or/ surgical procedures, administration of injections, and/or other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

APPOINTMENT REMINDERS
I acknowledge that this practice/facility may call for appointment reminders and/or cancellations. This contact may be by phone, in writing, email, or otherwise and may involve leaving a message on an answering machine or any other device available. No disclosure of medical information will occur while leaving messages. If you have any questions, objections and/or preferences, please inform us. This practice/facility will charge the patient $25.00 dollar for every missed appointment NOT cancelled with a 24-hour advance notice.

CONSENT TO PHOTOGRAPH
I authorize ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC, and its affiliates to take pictures of me or my child medical condition or surgical procedure and to use these pictures for medical record and treatment purposes only.

CONSENT AND ACKNOWLEDGEMENT FORM

USE AND DISCLURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, understand that as part of my health care, ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided &
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

	RELEASE OF INFORMATION
________ Initial	I authorize the ADRIANA VILLA, M.D. / VILLA DERMATOLOGY CENTER, LLC to release copies of information in their possession, as acquired in the course of my or my child's examination and/or treatments, to my insurance carriers in connection with my treatment for the purpose of any insurance or Medicare payments, or health care operations. - This facility and its affiliates - Utilization review agencies or auditors - Physician (Attending and consulting) - Other allied health professionals

I understand that I may revoke this consent in writing, I also understand that by refusing to sign the consent or revoking this consent, the ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC reserves the right to change their notice and practices and prior to implementation, in accordance to Section 164.520 of the Code of Federal Regulations. Should ADRIANA VILLA, MD. / VILLA DERMATOLOGY CENTER, LLC change their notice, I have the right to obtain a copy of any revised notice.

I acknowledge that this form has been fully explained to me and that I have read and understand each of the provisions appearing on this form, and that by signing this form, I consent to these provisions individually and collectively.

Patient Signature	**Date**
Print Name	

For Office Use Only

☐ **Consent Received by:**	**Consent Received Date:**
☐ **Consent refused by patient and treatment refused as permitted**	