Skin Care Specialty Physicians
1447 York Road, Suite 301
Lutherville, MD 21093
(410) 252-9090

Receipt of Office and Financial Policies

I have received and read the office and financial policies. I have a complete understanding of these policies and am aware that I may contact the office at any time with questions and concerns regarding these policies. I understand that these policies may change at any time without notice. A current copy of these policies will be kept at the front desk at all times and may be requested at any time. I agree to adhere to all of the office and financial policies as outlined.

Receipt of Notice of Privacy Practices (HIPAA)

I have read and understand the Notice of Privacy Practices. I am aware that I may obtain a detailed copy of the Notice of Privacy Practices from the front desk at any time and that I may contact the office with any questions or concerns. I understand that my personal health information, including demographics, lab results, medical records, and appointment times may only be discussed with those listed below:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that I am responsible for the accuracy of the information on policy. I authorize payment of medical benefits to the physician(s) for all services rendered. I also authorize release of any medical or other information deemed necessary to process the claim.

Patient Name (Printed) _____

Patient or Legal Guardian Signature _____ Date ____/____/_____

Legal Guardian Name (If not the patient) _____

Emergency Contact Information

Name	**Relationship**	**Phone Number**