HUNTERDON DERMATOLOGY, LLC

Christopher T. Cassetty, M.D.

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Flemington, NJ 08822

908-782-1647 phone
908-782-7296 fax

PATIENT AUTHORIZATION SECTION

AUTHORIZATION TO PAY BENEFITS TO PHYSICAN:
I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. I understand I am financially responsible for charges not covered by my insurance. I further authorize:

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier information needed to determine benefits.

ACKNOWLEDGEMENT OF OUT OF NETWORK STATUS:
I understand that Hunterdon Dermatology, LLC does not participate with medical insurance providers beyond standard Medicare. Anything other than standard Medicare coverage, will be considered out of network and I will be financially responsible for payment of charges incurred.

A photostatic copy of this authorization shall be considered as valid as the original. This authorization may be revoked by me in writing.

_____
Patient's Printed Name

_____
Signature of Patient (Parent if Patient is a Minor) Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Hunterdon Dermatology, LLC's Notice of Privacy Practices.
I may refuse to sign this acknowledgement of receipt.

_____
Signature Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Staff initials

_____ *Individual Refused to Sign*
_____ *Communications barriers prohibited obtaining the acknowledgement*
_____ *An emergency situation prevented us from obtaining acknowledgement*
_____ *Other:*