GARRETT M. CRABTREE M.D. - DERMATOLOGY

INSURANCE AND BILLING AUTHORIZATION

I understand that I am personally responsible to Garrett M. Crabtree, M.D. (The Practice) for any charges incurred for services performed, regardless of insurance coverage. I accept full FINANCIAL RESPONSIBILITY for the patients account in accordance with the regular rates and terms of the Practice Policy I understand most health insurance carriers require The Practice to file a claim for my services, but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. These amounts may include co-payments, deductibles, and fees not covered by my health insurance. IF MY INSURANCE CARRIER REQUIRES A REFERRAL FOR MY OFFICE VISIT, I UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN THIS AND PRESENT THE REFERRAL AT THE TIME OF MY VISIT (IF NOT BEFORE)

Failure to obtain a referral, if required, does not release me from my responsibility to The Practice. SERVICES PROVIDED WITHOUT A REFERRAL, IF A REFERRAL IS REQUIRED, REMAIN MY RESPONSIBILITY.

I understand that if I am not covered under a current insurance policy or I do not present a current Insurance card at the time of service, that I will be responsible for payment in full at the time services are rendered.

I, hereby authorize The Practice to submit a claim to my insurance carrier or its intermediaries related to services rendered by any physician or medical provider employed by Garrett M. Crabtree, M.D., and direct my insurance carrier or its intermediaries to issue payment directly to The Practice and/or provider who accepts assignment.

_____ _____

Signature Date

CONSENT FOR CARE AND TREATMENT OF DEPENDENT

PERMISSION FOR TREATMENT is hereby granted to Garrett M. Crabtree, M.D. to render such medical and surgical treatment as deemed necessary for:

_____

Dependents Name

_____ _____

Signature of Parent or Guardian Relationship to Patient

NOTICE OF PRIVACY PRACTICES

I acknowledge Garrett M. Crabtree, M.D. (The Practice) has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ _____

Signature Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient