DeSpain Cayce
DERMATOLOGY CENTER
and MEDICAL SPA

HIPAA Privacy Practice Act and Payment Authorization

ACKNOWLEDGEMENT OF HIPAA PRIVACY ACT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers and to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of DeSpain Cayce Dermatology's Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact **Dr. Kimberly Cayce** to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

PATIENT NAME X _____

DOB X_____

SIGNED X _____

DATE X_____

IMPORTANT INFORMATION/AUTHORIZATION

I hereby authorize the office of DeSpain Cayce Dermatology to release any information necessary to secure payment on my behalf or on behalf of my dependents. I authorize payment directly to the office of DeSpain Cayce Dermatology for treatment on any and all services rendered. I further understand that I am responsible for all fees not paid by my insurance and the balance is due within 30 days receipt of a patient statement. If my account balance becomes delinquent and is forwarded to an attorney or collection agency, I am responsible for any collection and interest fees, attorney fees and court costs. I certify all information given is true and accurate. A copy of my signature is as valid as the original. IF my insurance requires a referral, I am responsible for the referral and I understand that I'm responsible for the balance should my insurance not pay.

SIGNED X _____

DATE X_____