The Notice of Privacy Practice for the office of Dermatology Partners of the North Shore, LLC is available at the front desk and on our website at http://www.dpns.net. The Notice of Privacy Practices may change from time to time, and you are welcome to request a revised copy at your next visit or call our office to request a copy.
SECTION I – This document provides your acknowledgement that you have had an opportunity to read our Notice of Privacy Practices.
SECTION II – To authorize other persons to request, receive, or discuss your private health information (PHI).
SECTION III – Acknowledgement that you have read and agree to our Financial Policy.
SECTION IV – Authorize DPNS to send and receive PHI to and from your insurance company.

SECTION I – ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have had an opportunity to read the Notice of Privacy Practices for the office Dermatology Partners of the North Shore, LLC.

Print Patient Name: _____ Signed: _____ Date: _____

SECTION II – PATIENT COMMUNICATION AUTHORIZATION

Persons Authorized to Receive Information about my Healthcare

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize physicians and staff to communicate and/or leave messages for me at:

	(Circle One)	
Home	Yes	No
Work	Yes	No
Cell	Yes	No

Other: _____

SECTION III – FINANCIAL POLICY EFFECTIVE 11/1/09

I certify that I have been given an opportunity to read DPNS's financial policy and agree to make all payments due to Dermatology Partners of the North Shore as a result of all co-pays, co-insurances, deductibles, pre-existing conditions, cosmetic procedures, product purchases, and any other out-of-pocket expenses incurred not covered by insurance.

Signed: _____ Relationship to Patient: _____ Date: _____

SECTION IV – INSURANCE AUTHORIZATION

INSURANCE PAYMENT RELEASE

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process an insurance claim.

Signed: _____ Relationship to Patient: _____ Date: _____

MEDICARE PATIENTS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed: _____ Date: _____

400 Skokie Blvd
Suite 475
Northbrook, IL 60062

P: 847-272-4433 F: 847-272-4434