

Nash Dermatology, LLC

Patient General Consent Form

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physicians, his/her associates or assistants of Nash Dermatology, LLC.

Patient Signature

Date

Person other than patient

Relationship to Patient

Assignment of Benefits and Guarantee of Account

In consideration of all services and supplies provided by Nash Dermatology, LLC, I understand and agree that I have full responsibility to pay Nash Dermatology, LLC. I understand that the charges not covered by my insurance remain my responsibility and assign insurance benefits to Nash Dermatology, LLC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Nash Dermatology, LLC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I agree, in order for Nash Dermatology, LLC to coordinate my care, service my account or to collect monies I may owe, Nash Dermatology, LLC and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Nash Dermatology, LLC may also contact me by sending text messages or emails, using any e-mail address I provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

Patient Signature

Date

Person other than patient

Relationship to Patient

Notice of Privacy Practices Receipt

I have received the Notice of Privacy Practices provided by Nash Dermatology, LLC.

Patient Signature

Date

Person other than patient

Relationship to Patient

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____
