Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to Fresh Dermatology, P.A. for any services furnished the patient listed above by Dr. Thrash and her staff and associates, and I assign my right to receive these payments to Fresh Dermatology, P.A.

I authorize Fresh Dermatology, P.A. to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan will not direct payment to Fresh Dermatology, P.A., I agree to forward to Fresh Dermatology, P.A. all health insurance payments, which I receive for the services rendered by Dr. Thrash and her staff and associates.

I authorize Fresh Dermatology, P.A. or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

Signature Patient/Guardian:_____

Printed Name: _____

Date: _____

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Fresh Dermatology, P.A.
Attn: HIPAA Officer
1008 RR 620 S. Suite 101
Lakeway, Texas 78734
512-615-5600

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

Patient/Legal Representative:_____ *Date*: _____