

The Updegraff Clinic for Allergy & Dermatology, P.C.

Patient name: _____

Date:

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I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to The Updegraff Clinic for any services furnished to me. I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgement of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I also authorize the release of any information required to process insurance claims Including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Financial Arrangements

For your convenience, The Updegraff Clinic for Allergy & Dermatology participates in the following insurance plans:

Blue Cross

Arizona Foundation

Medicare

CCN

Mayo Health Plan

Railroad Medicare

Lifewise

Humana

Schaller Anderson

Aetna (PPO & POS II)

We offer the following methods of payment: Cash, Personal Check, Visa, and MasterCard. If you do not have insurance, we require full payment at the time of service. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance prior to your appointment.

Photographs

I authorize the taking of photographs as may be appropriate for medical use only.

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of The Updegraff Clinic's "**Notice of Privacy Policies**", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restriction(s) concerning my personal medical information:

This authorization may be revoked in writing by me at any time.

Signed: ^ _____

Date:.

Signature: _____

Date:

(If patient is a minor - signature of parent/guardian)