



PRIVACY NOTIFICATION

I have read and/or been offered a copy of the Notice of Privacy Practices for Johnson County Dermatology, PA. I understand that I may request a copy of the Privacy Notification in the future by contacting Johnson County Dermatology PA at (913) 764-1125 or by writing to 153 W 151st St, Suite 100, Olathe, KS 66061.

Signature _____ Date _____

CONSENT FOR RELEASE OF INFORMATION

Who can we speak with about your medical information, care, and/or billing information?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

*If left blank, we will be unable to speak with anyone other than the patient OR parent/legal guardian of a minor patient.
* If you need to make changes to the above preferences, please do so in writing.*

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claims and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans, to Johnson County Dermatology for office visits, procedures or hospital charges.

I understand and agree that I am financially responsible for all charges incurred regardless of potential insurance benefits, including but not limited to Co-Payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand that it is my responsibility to verify with my insurance company the physician treating me is covered under my insurance and to get referral(s) and/or authorization(s) for services prior to the service. Further, I understand that services cosmetic or not-medically necessary are not billable to insurance, and I am responsible for paying for those services. Should I have a cosmetic service in addition to medically necessary services during the same visit, I will pay for the cosmetic services, and medically necessary services will be billed to my insurance.

Signature _____ Date _____

*The following provided information will only be used for government reporting purposes.

RACE

- White
- Black/African American
- Asian
- American Indian/Alaska Native
- Decline

ETHNICITY

- Hispanic/Latino
- Not Hispanic/Latino
- Decline

LANGUAGE

- English
- Spanish
- Indian
- Russian
- Decline
- Other _____

How did you hear about our office? _____

Please list any family members that are patients in our office: _____

**Amanda Tauscher, MD., FAAD - Jan Marie Kroh, MD., FAAD - Trisha Prossick, MD., FAAD - Jennifer Eyler, MD.
Laura Stigge MPA-C - Jesse Watts MPA-C - Retta Kritzer MPA-C - Kristin Sands MPA-C**