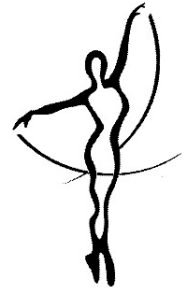


Just Brahmatewari, MD
Cosmetic Surgery and Dermatology



**HIPAA
PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the executive of this Consent.
- The Practice reserves the right to change the Notice of Privacy Practices

This consent was signed by:

Signature

____/____/____
Date

Witness:

Signature

____/____/____
Date

300 Arthur Godfrey Rd., Suite 100, Miami Beach, FL 33140
Ph: 305.532.3186 Fx: 305.532.7480

Today's Date ____/____/____

PATIENT INFORMATION

Name _____
 Last First M.I.

Mailing Address _____
 Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

PARENT OR RESPONSIBLE PARTY

Name _____
 Last First M.I.

Mailing Address _____
 Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

Referred By: _____ Primary Care Physician _____ Phone _____

PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Consent for Treatment

I hereby voluntarily consent to the rendering of medical treatment by the physicians and medical staff of J. Brahmatewari, M.D., P.A. This may include examination, diagnostic and/or any other such medical treatment deemed necessary for the diagnosis and treatment of my medical condition.

Authorization to Release Medical Information

I hereby authorize the physicians and staff of J. Brahmatewari, M.D., P.A. to release any medical information acquired in the course of my examination and treatment necessary for the processing of this claim and/or for the purpose of any insurance payments. I further authorize the release of said information to my primary care physician and/or referring physician if applicable. I further authorize the use of blinded review of medical data for outcome analysis, quality management or internal project monitoring.

Assignment of Insurance Benefits

I hereby authorize my insurance company to make payments on my behalf of any and all individual group benefits directly to the provider, physicians and medical staff of J. Brahmatewari, M.D., P.A. for medical services rendered to me.

Medicare/Medicaid Assignment of Benefits

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that Medicare, Medicaid, and supplementary insurance companies make payments of authorized medical benefits directly to the physicians and medical staff of J. Brahmatewari, M.D., P.A. on my behalf.

Guaranty of Payment

I understand that I am financially responsible for payment to the physicians and medical staff of J. Brahmatewari, M.D., P.A. for any charges not covered or allowable by my insurance company and all applicable out of pocket expenses, including deductibles, co-insurance, and co-payments. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to J. Brahmatewari, M.D., P.A. plus any attorney fees if applicable.

I, _____ (Print Name) ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE PROVISIONS APPEARING ON THIS FORM, I CONSENT TO THESE PROVISIONS INDIVIDUALLY AND COLLECTIVELY.

PATIENT OR LEGAL GUARDIAN

WITNESS

DATE