PRESIDIO DERMATOLOGY

Consent for Communication of Medical Information:

My text/mobile phone number is: (_____)_____

I give permission to leave a voicemail with results/medical information at this number.

I give permission to discuss my medical information with (for example, a spouse or relative):

_____ (name) _____ (relationship)
_____ (name) _____ (relationship)

I authorize Sutter Health and its affiliates to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by Sutter Health or its affiliates under my cell phone plan.

I know that I am under no obligation to authorize Sutter Health or its affiliates to send me text messages. I may opt-out of receiving these communications at any time by calling the Service Desk @ (877) 607-6484, or by responding STOP to 622622. Please allow 2-3 business days for processing.

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Sutter Health and its affiliates to the phone number that I have provided.

X Patient Name: _____ **Date of Birth:** _____

X Signature: _____ **Date:** _____

Fax: Patient Services Contact Center, Attn: My Health Online, (877) 607-6484,
Mail: Patient Services Contact Center, Attn: My Health Online, P.O. Box 255386, Sacramento, CA 95865-5386

HIPAA and Insurance Agreement

I have been given a copy of Presidio Dermatology's Notice of Privacy Practices as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
I understand that should Presidio Dermatology not participate with my insurance payment is due and payable at the time services are rendered. I understand that I am responsible for any health insurance deductibles and coinsurance as well as for any non-covered services. I understand that should insurance membership verification not indicate coverage, I agree to pay in full for services rendered.
If Presidio Dermatology files a claim with my insurance company, I authorize necessary medical information to be released and payment of medical benefits (not paid at the time of service) directly to Presidio Dermatology.

X Patient Signature/Responsible party: _____ **Date:** _____