Patient Acknowledgement and Authorizations

Select the appropriate office location

San Jose/Los Gatos 2420 Samaritan Drive San Jose, CA 95124	Mountain View 525 South Drive,Suite 115 Mountain View, CA 95040	San Jose / O'Connor 2100 Forest Avenue, Suite 103 San Jose, CA 95128	Saratoga 18988 Cox Avenue, Suite B Saratoga, CA 95070	Los Altos 129 Fremont Avenue Los Altos, CA 94022	Monterey/Ryan Ranch 9781 Blue Larkspur Lane, St Suite 100 Monterey, CA 93940
San Mateo 136 North San Mateo Drive,2nd Floor San Mateo, CA 94401	San Francisco Lauriel Heights 3905 Sacramento Street, Suite 201 San Francisco, CA 94118	San Francisco Pacific Heights 2100 Webster Street, Suite 318 San Francisco, CA 94115	Salinas 559 Abbott Street,Suite A Salinas, CA 93901	Santa Cruz County 204 Green Valley Road Freedom, CA 95019	Monterey 977B Pacific st Monterey, CA 93940
South San Jose 393 Blossom Hill Road,Suite 290 San Jose, CA 95123	Daly City 1800 Sullivan Avenue,Suite 403 Daly City, CA 94015	Castro Valley 20055 Lake Chabot Rd Ste 150 Castro Valley, CA 94546			

ll Patients, Please Read and Sign:

This form is required to allow us to evaluate and treat you, and to bill and communicate with your insurance company.

I authorize the California Skin Institute to conduct examinations, and perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable.

The California Skin Institute is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such ervices rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers' compensation insurance company, other third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other Intermediaries responsible for payment of services rendered. The release of information consent may be revocated at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

In consideration of medical goods and services provided by the California Skin Institute, I give all rights, title and interest to the medical/surgical/supply reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefit including Medicare Part B. I remain fully responsible for payment of any and all charges not covered by insurance.

I have read the above acknowledgment and authorization. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party's Signature: Date Signed

Patient's Printed Name: Patient's Age *

* NOTICE: If patient is a minor (under 18 years of age) the parent of responsible party must complete and sign the Consent for Treating of Minor Form.