

I request that payment of authorized benefits be made on my behalf to M D Aesthetics and Dermatology LLC for any services furnished to me by Dr. Gabriel J. Martinez-Diaz, employees and associates. I assign my right to receive these payments to M D Aesthetics and Dermatology LLC.

I authorize M D Aesthetics and Dermatology LLC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my insurance carrier and its agents will not direct payment to M D Aesthetics and Dermatology, LLC I agree to forward to M D Aesthetics and Dermatology, LLC all health insurance payments, which I receive for the services rendered by Dr. Gabriel J. Martinez-Diaz, employees and associates.

I authorize M D Aesthetics and Dermatology, LLC or any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge that this authorization will be valid for all subsequent visits unless cancelled in writing by me or an authorized agent.

I designate M D Aesthetics and Dermatology, LLC as an authorized representative to act on my behalf in regard to claims submitted to any employee health plan or other source of Third-Party Coverage for Services rendered by M D Aesthetics and Dermatology, LLC. This designation includes, but is not limited to, initial determinations, requests for documents, requests for additional information and appeals. I further authorize M D Aesthetics and Dermatology, LLC to execute any documents necessary to process claims for reimbursement of charges for Services received by Patient.

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR RELEASE AND USE OF  
CONFIDENTIAL INFORMATION Effective date February 1st, 2018

I have received, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

I ACKNOWLEDGE AND AGREE THAT NO AMENDMENT TO THIS FORM IS PERMITTED. I MAY REQUEST AMENDMENTS TO MY MEDICAL RECORDS IN ACCORDANCE WITH STATE AND FEDERAL LAW AND REGULATION

With this consent, MD Aesthetics and Dermatology, LLC or our agents may call my home, cell or other alternative location, may reach you via email, or text message, and leave a message on voicemail or in person, including but not limited to, appointment reminders, billing items and any calls pertaining to my care.