Dermatology Affiliates, P.C.
Over 18 Guarantor Change Form

Congratulations! You are now 18 years of age and legally responsible for your own medical bills. Please review the information below for accuracy and make any necessary changes on this form.

Patient Name:
Date of Birth:
Address:

Telephone: _________________ (home) / _________________(work) / __________________ (cell)

Employer: _______________________________ / School: __________________________________

If a parent/guardian is willing to receive and pay your bill, please give their address here:

Parent/Guardian's Name: _______________________________________
Parent/Guardian's Address: _______________________________________
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Parent/Guardian's Telephone:
_____________________ (home) / _____________________(work) / _____________________ (cell)

Note: By requesting that bills be sent to your parent/guardian, you give Dermatology Affiliates permission to discuss your medical services, appointments, billing, and insurance issues with this person.

Please Note: A copy of this form may be sent to the parent/guardian listed above to confirm accuracy and acceptance of bills on your behalf. If your parent/guardian does not pay the bill you are responsible for payment. This delegation of responsibility expires on your 21st birthday unless you renew it.

I understand that I may remove these privileges or change the information on this form by notifying Dermatology Affiliates in writing.

PRIVACY PRACTICES NOTICE & WRITTEN ACKNOWLEDGEMENT FORM
I have been offered a copy of DERMATOLOGY AFFILIATES, P.C.'S Notice of Privacy Practices.

Signature of Patient:____ Date_____________________

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION
I request payment of authorized insurance benefits be paid to DERMATOLOGY AFFILIATES, P.C. & authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient:____ Date____________________