# Patient Consent Form

**Please fax to 214-414-2533 or email to sales@dermitech.com**

**To be filled out by the patient and sent to Dermitech.**
**Please call 214-377-8144 for assistance.**

## Patient

First Name ______________________ Last Name ____________________ DOB ____ / ____ / _______

Address ________________________________________________________ Cell Phone __________________

City ____________________________ State _______ Zip ____________ Alt Phone ___________________

Email _________________________________________________________

## Texts

☐ I agree to receive text messages from Dermitech Phototherapy related to my phototherapy order. Message frequency varies. Message & data rates may apply. You can reply STOP to opt out at any time. View terms and privacy policy at www.dermitech.com.

## Verify Insurance?

**Verify Health Insurance Benefits?**

☐ **No** Contact me to discuss self-pay options (skip to next section)

☐ **Yes** I wish to have insurance coverage checked and contact me to discuss options.
I authorize the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Dermitech Phototherapy, its suppliers or order fulfilling partners. 2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s). 3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns. 4. Dermitech Phototherapy or order fulfilling partners to obtain medical or other information necessary to process my claim(s), including determining eligibility and seeking reimbursement for medical equipment provided.

Primary Insurance Company _____________________________

Member ID _____________________________

Secondary Insurance Company ___________________________

Member ID _____________________________

## Confirmation

I confirm that the above information is accurate and complete to the best of my knowledge. I authorize Dermitech Phototherapy or its suppliers or order fulfilling partners to contact me regarding my medical equipment order. I authorize any holder of medical information about me to release to Dermitech Phototherapy, my physician(s), caregiver, CMS or its agents.

☐ ✓ Check Here

I have read and understand Dermitech Phototherapy's disclosure document that includes the HIPAA Privacy Policy, Scope of Services, Patient Responsibilities, Patient Rights, Warranty Coverage, and Problems/Complaints.

**Signature** ____________________________________________________ **Date** ____ / ____ / _______

Relationship to Patient: ☐ Self ☐ Parent (patient is under 18) ☐ Authorized Representative

If Parent or Authorized Rep., please print name ____________________________________________

If Authorized Rep., reason patient can't sign ______________________________________________