PREMIER DERMATOLOGY LTD. CONSENT FORM

CONSENT FOR TREATMENT

I give consent to my physician/provider and their assistants to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction; including laboratory procedures, monitoring, liquid nitrogen therapy, steroid injections, shave removals, and diagnostic biopsies. I understand I have the right to decline these services at any time.

_GENERAL ACKNOWLEDGEMENTS

I consent to have my picture taken for the medical record to assist in tracking the management of my medical condition, if necessary. If taken, these pictures will NOT be made public and are considered a private, protected part of the medical record.

_CANCELLATION/ NO-SHOW POLICY

I am aware that Premier Dermatology has a policy requiring <u>at least one business day</u> cancellation notice for all appointments. If I do not give adequate notice, I understand that they reserve the right to charge me up to \$50 for a no-show appointment. As a courtesy, Premier Dermatology will make every effort to call and confirm appointments in advance. If I no-show an appointment twice then I will be assessed the \$50 fee prior to scheduling a third appointment. A third no-show will result in the patient being discharged from Premier Dermatology.

_AGREEMENT TO PAY

I understand that if I am uninsured or have an insurance that is not accepted at the practice, that I will be responsible for a payment of \$100 IN FULL at the time of service. I understand this may be an underpayment or overpayment and that I may receive a balance as a result of my appointment. I understand that all cosmetic services not covered by insurance are due at the time of service. Returned checks will be assessed a fee of \$26.00.

INSURANCE ACKNOWLEDGEMENT

I understand that it is my own responsibility to know whether the providers of Premier Dermatology Ltd. are innetwork for my insurance and at no time does Premier Dermatology guarantee all medical care will be covered. I understand that it is my responsibility to pay any charges that are not paid by my insurance company, and I am responsible for knowing and paying my <u>applicable co-pays and deductibles</u>. Premier Dermatology uses an outside pathology lab for the processing of its specimens. Although the vast majority of insurance plans will pay for the lab to process specimens, it is my responsibility to know if my insurance has a <u>preferred lab</u> and bring it to the attention of the practice.

_RELEASE OF MEDICAL INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance application and prescriptions. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. **NAME OF PCP/REFERRING PROVIDER**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I am aware that Premier Dermatology has a **Notice of Privacy Practices**, which states how my health information may be used/disclosed. I acknowledge that I have reviewed it and it has been made available to me.

PHONE MESSAGE CONSENT: It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. You may also wish to have an individual designated to also receive results or call on your behalf. This is to acknowledge that you authorize us to:

* Leave a detailed message on voice mail/answering machine YES_____ NO_____ (initial yes or no)

* Leave a detailed message with individual answering the phone YES_____ NO_____ (initial yes or no)

* List any individual(s) who may call or receive medical information, including results, on your behalf:

Patient/responsible party signature _____

Please check: \Box Self

□ Parent/legal guardian (if under 18)