ACKNOWLEDGEMENT OF OFFICE POLICIES

Name: _____

Date of Birth: _____

Please review and sign after reading each policy listed below

General Patient Authorization: I hereby authorize providers of Dermatology Associates of Uptown (the "Practice") to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

Receipt of Notice of Privacy Practices: The Practice's Notice of Privacy Practices provides information about how the Practice may use and disclose protected health information about me. The Notice of Privacy Practices contains a Patient Rights section describing my rights under the law. I acknowledge that I have had the opportunity to review the Practice's Notice of Privacy Practices. The Practice reserves the right to change its Notice of Privacy Practices.

Cancellation Policy: If a patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. The Practice reserves the right to charge a $50 fee if a patient does not cancel his/her appointment within 24 hours or a loss of a deposit if a patient does not cancel a surgical appointment within 24 hours. Administrative fees incurred for failure to provide cancellation notice are not billable to insurance or any other third party payor. These policies include appointments with all providers and estheticians.

Release of Medical Information:

☐ **I do** ☐ **do not** (*select one*) authorize the Practice and its designated representatives to release my medical information to my primary care physician. If authorized, please provide name of physician: _____.

If at any time you should need a copy of your medical records, we require a written release to be signed and dated. The form is available at our front desk and can be requested by email. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. Absent providing a secure fax number, records must be MAILED to your address of record. Copies of blood work and pathology reports are provided at no charge, copies of your complete medical record or office notes will require $25 fee.

The Practice requires a written records release form to transmit records to any physician or medical organization that is not listed as your referring physician. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release form for each physician you wish to receive your records.

Contact Permission: In the event that the Practice needs to contact you (the patient), regarding an appointment, lab result, medication, or any other reason, it is permissible to:

☐ **Yes** ☐ **No** (*select one*) Leave a message on an answering machine/voicemail system.

☐ **Yes** ☐ **No** (*select one*) Speak with other authorized individuals listed below.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

☐ **Yes** ☐ **No** (*select one*) Send a text message to the following number: _____

Expiration of and Right to Revoke Authorization to Disclose Protected Health Information: I understand that I can withdraw my permission set forth above at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Release of Medical Information" and "Contact Permission". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

The duration of this authorization is valid until the earlier to occur of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): *Month:* _____ *Day:* _____ *Year:* _____.

Physician Assistant, Nurse Practitioner, & Esthetician Information: The Practice may staff physician assistants, nurse practitioners, and estheticians to assist in the delivery of medical dermatology care. A physician assistant ("PA") is not a doctor but is a graduate of a certified training program and is licensed by the Texas Physician Assistant Board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. In collaboration with a physician, nurse practitioners can diagnose, treat, and monitor common acute and chronic diseases. Estheticians provide services as directed by a PA, nurse practitioner or physician. I understand that at any time I can request to see a physician. I have read the above and hereby consent to the services of a PA, nurse practitioner, or esthetician for my health care needs.

ACKNOWLEDGEMENT OF OFFICE POLICIES

Unaccompanied Minors (Under 18 Years Old): New patients who are minors must have a parent or legal guardian present for the new patient visit. Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. Should you wish for us to see your teen/young adult child when they arrive at the office unaccompanied please read, indicate and sign below:

☐ **YES** ☐ **NO** (*select one)* I hereby grant the physicians and providers at the Practice permission to treat my child when they arrive at the office unaccompanied. I understand this may include changes in current therapy my child is receiving including treatments or minor skin surgery.

Signature: _____ Date: _____

Proof of Identity: The Practice requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record as a means to document who we are treating.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ _____

Signature of Patient or Guardian **Date**

_____

Relationship

FINANCIAL POLICY NOTICE

Name: _____

Date of Birth: _____

Thank you for choosing Dermatology Associates of Uptown (the "Practice"). Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, MasterCard, Visa, Discover, American Express and CareCredit.

Please review and sign after reading each policy listed below

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify the Practice of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths and Mohs surgery are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Copayments: I understand that all copays are due at the time of my appointment and before I see the provider. Given that the Practice's physicians are specialists, a higher copay may be required.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between the Practice and my insurer will be due at the time of service.

Managed Care (HMO) Plans or Health Select: I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. The Practice will strive to keep me informed of visits remaining on a referral and/or the expiration date but it is ultimately my responsibility to know this information and to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in me bearing complete financial responsibility for any and all services received.

Benefit Representation: I understand that the staff of the Practice will make every effort to accurately verify my insurance benefits but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at the Practice all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize the Practice to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand that the Practice utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from the Practice. I acknowledge that payments made to the Practice are for services rendered by the Practice and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that the Practice does not accept Worker's Compensation cases.

Returned Checks: I understand that checks presented to the Practice as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check fee of $25. Balances must be handled by cash, credit card or money order. The Practice reserves the right to represent returned checks electronically for their face value plus the returned check fee.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact the Practice before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

_____ _____

Signature of Patient or Guardian/Guarantor **Date**

_____

Relationship