ART OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

OFFICE POLICIES

NOTICE OF PRIVACY PRACTICES

The notice of Privacy Practices for Art of Dermatology provides information about how my protected health information (PHI) may be used and disclosed. This notice also describes how such information may be used, released, or shared under the Health Insurance Portability and Accountability Act (HIPAA). As stated in Art of Dermatology, the terms of this notice may change. I may obtain a revised copy containing such changes by contacting office personnel. By signing below, I am acknowledging that Art of Dermatology has presented me with the most recent copy of the Notice of Privacy Practices and the Health Insurance Portability and Accountability Act. (HIPAA).

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for the above stated to furnish medical care and treatment as considered necessary and proper for diagnosis and treatment. This includes cryotherapy, cautery, biopsies, excisions and other procedures deemed medically necessary by the medical health care provider. This may also include photography. I understand that the medical health care provider will discuss with me prior to any procedure or treatment and this will be documented in my medical record. This shall be valid throughout all treatment for this condition and/or disease process.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, from Medicare, Medicaid, private insurance and third-party payers, to the above stated. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

My insurance will be billed solely as a courtesy. I am responsible for the entire bill when services are provided. If my insurance carrier does not remit payment or notification to my provider within 60 days, the balance will be due from me. In the event that my insurance company requests a refund or payments, I will be responsible for the amount of money refunded to my insurance company. In the event my insurance company establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining.

PATHOLOGY/LAB SERVICES

Art of Dermatology PLLC uses third parties for our Laboratory work and pathology services. You/your insurance will receive an additional bill from the lab service provider (Quest, Beaumont, Pathology laboratory). We are unable to adjust these charges as they are provided by a separate entity.

COSMETIC SERVICES

All cosmetic services (whether single services or purchased in a package) are non-refundable. Results are not guaranteed, and payment is due in full at the time of service/purchase.

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REFERRALS
Your insurance plan may require a referral to be completed before seeing a specialist. It is your responsibility to obtain the proper referral in order to be seen for your appointment. If you don't have a referral at your appointment time, your appointment may be rescheduled and you could be charged a missed appointment fee of $50.00.

PRESCRIPTION POLICY
Please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Some Prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form set forth by the insurance companies. For oral medications, biologics, and some topical medications, the patient needs to be evaluated every 6 months. We cannot refill a prescription if the patient has not been evaluated within 12 months.

MINOR POLICY
All minor patients must be seen on the first visit with their parent/guardian/representative. Minor consent forms must be signed for future visits without a parent/guardian/representative.
Self pay services will be requested due on the date of service.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. I understand that Art of Dermatology is not a provider for Worker's Compensation and I may be held liable for the total amount of charges for services provided. I understand and agree that if I fail to show for a scheduled appointment or do not notify the clinic 24 hours in advance, I may be charged a fee of $50.00. For a procedure appointment such as surgery or a cosmetic/laser procedure, I must cancel 48 hours in advance or I may be charged a fee of $100.00. This fee is required to be paid prior to scheduling another appointment.

The above information has been read and explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

PROCEED TO ORANGE BUTTON IN TOP RIGHT CORNER OF YOUR SCREEN MARKED "READ AND CONSENT" PLEASE.

Sign below

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