



Patient Information Confidentiality Policy and Statement

Policy

It is the obligation and policy of **Dermatology & Dermatologic Surgery, Ltd.** to maintain the confidentiality of all patient information including, but not limited to, medical record information, and to protect each patient's right to privacy.

Rules and Procedures

Employees shall not reveal the identity of a patient or discuss confidential patient information with any person(s) outside of the medical practice or among employees of the medical practice except as i) authorized by patient; ii) required for the treatment or care of the patient; iii) required for billing; and iv) required by law.

Employees shall use discretion when discussing or disseminating information about a patient's treatment or condition in order to avoid inadvertent disclosure of confidential information. All patient records and reports are to be filed following review by the physician.

Any unauthorized disclosure of confidential patient information will subject the employee to disciplinary action, up to and including immediate termination.

PATIENT PAYMENT POLICY

Thank you for choosing **Dermatology & Dermatologic Surgery, Ltd.** We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. This information and your signature will be stored electronically and reformatted for your medical record. **Please sign below that you have read and agree to this Policy.**

Payment for service is due in full at the time of service unless you have one of the following plans: **Aetna PPO/POS, Open Access/Aetna Select, Blue Shield PPO, Cigna PPO, CorCare, Corvel, Humana PPO, Medicare, MultiPlan, PHCS, United HealthCare and Unicare PPO.**

- We accept cash, check, Discover, Visa and Mastercard.
- All fees are based on the type of service provided for your care and related services. Our fees are very competitive for this region.
- When making an appointment with one of our physicians, it is your responsibility to confirm with our office and your insurance company that the physician is currently under contract with your plan; prior to your appointment it is your responsibility to know your plan's benefit policies. **If your plan has a co-payment, you will be expected to pay your co-payment prior to being seen by the doctor.** In order to file a medical claim with your insurance, we must have a current copy of your medical insurance card along with all the required information. Without the insurance card, we will be unable to file a claim with your insurance, and you will be responsible for the charges for the day. Unpaid balances are expected to be paid in full prior to additional services rendered unless other financial arrangements have been made.
- In the event your Insurance Carrier deems the service rendered to be Medically Unnecessary and/or Medically Unproven (Experimental and Investigational) the patient will assume all financial responsibility.
- For elective or uncovered surgical services, full payment is due on the day of surgery, with the exception of liposuction, in which full payment is due 7 days prior surgery.
- A parent or guardian must accompany a minor (18 years or younger) for the first visit to our office. The parent(s) or guardian(s) are responsible for providing current insurance information for the minor and/or payment in full for services provided. For follow-up visits, I authorize medical treatment to be rendered in my absence. Any unpaid balance or **co-payment** on a minor's account is the responsibility of the minor's accompanying adult, regardless of any and all custody/divorce arrangements that apply.
- If medical insurance coverage is not sufficient to satisfy the physician(s) charges in full, I acknowledge that the resulting balance is not covered by this assignment, that I will be responsible for payment of co-insurance and deductibles. As consideration for medical services rendered, I agree to pay the established rates of the physician(s) for all services, facilities and supplied rendered.
- If my account balance after any and all insurance payments and correspondence is overdue longer than **30** days, a monthly finance charge of **2%** will be added unless other financial arrangements have been made.
- If account is overdue longer than **60** days, it will be referred to a collection agency. This is a last resort, done reluctantly and after we have exhausted efforts for voluntary payment. I understand that a collection fee of **\$25** will be charged, plus reasonable attorney's fees and court costs when necessary, will be added to the balance referred.
- A charge of **\$25** will be added to your account for any check returned by your bank for insufficient funds.

I authorize my insurance benefits be paid directly to **Dermatology & Dermatologic Surgery, Ltd.**, when applicable. I authorize **Dermatology & Dermatologic Surgery, Ltd.** to release necessary medical or other information to my insurance company.

Furthermore, I request and authorize **Dermatology & Dermatologic Surgery, Ltd.** to release necessary medical information to my primary care provider. Not Applicable

This policy shall remain in effect until revoked by me in writing.

Acknowledgement and Authorization

I have read, understand, and agree to the above Patient Payment Policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility.

I have read the policy regarding confidentiality of medical record information. I have the opportunity to review the entire HIPPA regulation upon request, ask questions related to this policy, and at this time understand its intent and content. I am also aware that this signed statement of acknowledgement will be permanently stored electronically and reformatted for my medical record.

Dermatology & Dermatologic Surgery, Ltd. accepts assignment for patients enrolled in the **Medicare Insurance Program** and the patient(s) will only be responsible for deductibles, coinsurance and non-covered services. Assignment is accepted for Medicare supplemental insurance.

If applicable, I give permission for my medical condition and/or financial information to be discussed with my spouse, parent(s) and/or legal guardian(s).

X

Patient Signature

X

Parent or Guardian Signature