QUALDERM PARTNERS
A SKIN & AESTHETICS WELLNESS FAMILY

Financial Policy, Consent, and HIPAA Acknowledgement

Patient Name: _____

Today's Date: _____

- **Insurance Billing**: I consent for the practice to bill my insurance company according to the most recent insurance information and insurance card(s) including, Medicare and Medicaid Advantage Plan cards, that I have provided. I understand that all payment of all balances is my responsibility, including co-pays, co-insurance amounts, deductible amounts and services that are not covered by my insurance plan (such as cosmetic services). I understand that if claims are denied due to lack of current insurance information, I will be responsible for the balance.
- **Insurance Network:** I understand that it is my responsibility to ensure that this practice and the provider of services are in my insurance network and to obtain any referrals or authorizations required by insurance plan. If my claim is denied because I am out of network or failed to obtain a referral or authorization, I understand that I will be responsible for the balance.
- **Co-payment:** I understand all co-payments must be paid at the time of service. I understand co-payment and co-insurance are determined by my insurance. The practice accepts cash, check, Visa, MasterCard, American Express, Discover and Care Credit.
- **Deductible:** An annual deductible is the dollar amount I must pay out of pocket during the year for medical expenses before my insurance begins to pay.
- **Credit Card on File:** For any prearranged payment plans, the practice will keep credit cards on file (CCOF). We do not keep any credit card information on file in the office or on any of our computers. We use a secure, encrypted gateway that is completely compliant as required by law.
- **Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits. All co-pays or monies due are expected to be paid at the time of each service.
- **Determining Guarantor:** The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18. The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.
- **Self-Pay**: I understand and agree that if I do not have insurance or opt out of insurance coverage if permitted and elect to be seen as a self-pay patient, I have full financial responsibility for my visits and will pay for all services at the time of service, unless other arrangements have been made. I understand I will be subject to and will abide by the practice's self-pay policy. This agreement will remain in effect unless proof of insurance is provided at a subsequent date.
- **Good Faith Estimates:** If I am uninsured, or if I request that covered services not be billed to insurance, I understand that I may request a Good Faith Estimate of the total fees that I may be charged and that fees for all services must be paid on the date that services are rendered.
- **Past Due Balances:** I understand that if my account is over 90 days past due, this practice will send a statement and I will have 20 days in which to pay the balance in full. Partial payments will not be accepted unless previously negotiated. I understand that if the balance remains unpaid this practice may refer my account to a collection agency and/or I may be dismissed from this practice.
- **Late Arrivals or Missed Appointments:** I am aware that if I am late to my appointment I may be rescheduled. I also understand that multiple missed appointments without adequate notice and/or late arrivals may result in my dismissal from the practice. If I am unable to keep my appointment, I will notify this office at least 24 hours in advance. I understand failure to provide 24-hour notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is $50 for a Monday-Friday non-surgical medical visit and $100 for a Saturday non-surgical medical appointments. The no-show fee for cosmetics is $100 for a cosmetic consultation and $250 for a cosmetic procedure. The no-show charge for surgery related appointments, including a Mohs surgery, is $250. No-show charges are not billable to my insurance.

- **Prescription History:** I authorize this practice to request prescription history information electronically from my local pharmacy(ies) for the purpose of providing direct health care services unless otherwise revoked.
- **HIPAA Disclosure and Notice of Privacy Practices:** I consent for this practice to release information to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPAA Privacy Act. I understand that medical information disclosed may be used and forwarded to provide continuing treatment or care, for filing claims, and for all other healthcare operations. I have received this practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have had the right to review such notice prior to signing this consent form.
- **Use of my Contact Information.** I understand the practice may use my information to contact me regarding my treatment and payment, including through voicemail messages, text messages, and email, and for appointment reminders, billing matters, and test results (for benign test results, a message may be left stating such). I understand I can revoke this authorization at any time in writing to the practice.
- **Disclosure of Information to Others:** I authorize for the practice to contact the following person as my emergency contact: Name: _____ Telephone: _____
  Additionally, I voluntarily and at my discretion authorize the practice to verbally discuss my scheduling/appointment information, billing and payment information, prescriptions and refills, laboratory and test results (except HIV or genetic testing), and medical information (but not mental or behavioral health information), including my symptoms, diagnosis, medications and treatment plans with the below persons. I understand I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on my prior consent. I understand that I am responsible for notifying the practice if there are changes to those that may participate in my care. This form does not authorize releasing copies of my medical records to the persons below.

Name	Telephone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

My signature indicates that I have been given the opportunity to review this information, ask questions and have had my questions answered. I understand that I am financially responsible for all services as described in this consent form.

_____
Patient Signature

_____
Patient Date of Birth