

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

For treatment: This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

For payment: This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.

For health care operations: This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge a clear understanding of the Privacy Practices. I understand that Seaside Dermatology has the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that has been maintained by Seaside Dermatology. Any material changes to the Notice will be promptly posted in the office or on the Seaside Dermatology website. I will be given a copy of the latest version of this Notice at my next visit or I can contact Seaside Dermatology at the address above.

I understand that I may request in writing that Seaside Dermatology restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then Seaside Dermatology may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

No Show/Late Cancellation Policy

In an effort to ensure all patients receive care in a fair and timely manner, effective October 1, 2015, Seaside Dermatology will charge a No Show/Late Cancellation fee of \$100.00 for patients who do not show for their appointments or who cancel their appointment less than 1 business day before the appt. For example, an appointment on Monday must be cancelled by Friday the week before.

Biopsy Consent Form

Risks and Complications Specific to Skin Biopsies/ Excisions

- Bleeding
- Infection
- Pain
- Scar
- Incomplete Removal
- Recurrence
- Nerve Damage/Numbness
- Allergic Reaction to Anesthesia

Results and Postoperative Care

1. Keep the bandage on for 24 hours.
2. Let warm water in shower rinse over it starting tomorrow.
2. Keep covered with bandage and Aquaphor or Vaseline for one week, changing on a daily basis. If you have sutures, continue changing bandage until sutures have been removed.

The physician has explained to the patient/family/guardian the nature of the patient's condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches. The physician has discussed the likelihood of major risks or complications of this procedure including the specific risks listed above and (if applicable) drug reactions, hemorrhage, infection, complications from blood or blood components. The physician has also indicated that with any procedure there is always the possibility of an unexpected complication.

Rationale

A skin biopsy allows the dermatologist to test a lesion or rash under the microscope to obtain a diagnosis. It usually involves numbing the area with numbing medication, removing a small piece of skin, and then closing the area with some sutures. Sutures usually need to be removed in 2 weeks.

Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW.

In consideration of receiving services from a Seaside Dermatology facility, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire

prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. On the date of service, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance.

3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. It is your responsibility to notify this office immediately if your insurance coverage or company changes. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current.

4. We will bill your insurance company as a courtesy but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond we will follow up with an inquiry on your behalf. If, however, your insurance does not respond again, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will be happy to assist after you have contacted your insurance.

5. If your medical claim has not processed and your insurance company has not resolved your dispute, you may register a complaint with the South Carolina Department of Insurance. Our office will do everything we can to assist you, however you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

6. Any unpaid charges over 90 days old will be considered for an outside collection agency. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

7. Non-Insured: If you do not have medical insurance, you will be responsible for payment at the time of service for the service to be received that day, as well as any previous outstanding balance. If a procedure is necessary, payment may be required prior to the procedure.

8. Seaside Dermatology caps patient balances at \$250. While we expect all accounts to be current, we do realize the financial hardships that medical bills can carry. Should you need to be seen at our facility, you will be required to pay your balance down to at least \$250 before a visit takes place.

9. You will be assessed a \$20 service fee on all returned checks due to insufficient funds in addition to the amount of the actual check. If your account becomes delinquent, the guarantor is responsible for any collection fees, interest, or attorney fees.

10. Non-Covered Services: Some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. The patient is responsible for payment at the time of service for all services not covered by insurance.

11. Collection Agency Policy: You are financially responsible for services in the office. Furthermore, any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, you will be financially responsible for any and all costs and

fees relating to the collection of your debt. If an account is sent to a collection agency, an additional fee (45% collection fee/interest) will be added to the ending balance of the account sent to the agency.

11. Laboratories: If your insurance company requires a specific laboratory, it is your responsibility to notify us. Otherwise, we will send your specimen to a cooperating laboratory. If there are any costs related to the biopsy, pathology, cultures, or other lab work that your insurance carrier does not cover you will be responsible for those costs.

12. If you are enrolled in a Managed Care Insurance Plan (HMO) it is YOUR responsibility to obtain or ensure that a referral and/or authorization is supplied to our office from your primary care physician prior to the time of your appointment. We commonly schedule routine follow up exams as a courtesy to you upon checking out. Unfortunately, these future appointments may be outside of authorization extension allowance and require new authorization that our office is unable to complete on your behalf.

13. We are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.