HARTSOUGH DERMATOLOGY

BOARD CERTIFIED DERMATOLOGIST

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AGREEMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by ***Hartsough Dermatology***, employees or designees and authorize medical services, diagnostic procedures and medication as deemed necessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications, which may be given to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ***Hartsough Dermatology*** to release information required in the processing of application for financial coverage for services rendered. This authorization provides that my physician or my physician's staff may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. This authorization also includes any medical records containing information related to HIV (AIDS) testing and/or psychiatric care rendered to me if such records are released to an insurance company writing Life, Accident or Health Insurance or a Non Profit Health Care Service Plan Corporation to evaluate my claims or its liability under such policies or contracts or coordination of benefits pursuant to such policy or contract provisions. The information obtained will be treated as privileged and confidential and will not be released to any person without my expressed or written consent. Correspondence and test results will only be released to physicians involved in my care.

ASSIGNMENT OF INSURANCE BENEFITS/REFERRALS/PAYMENTS GUARANTEE/COLLECTION FEE/NSF FEE

I hereby authorize payment to be made directly to ***Hartsough Dermatology*** for insurance benefits payable to me. I understand that I am financially responsible to ***Hartsough Dermatology*** for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I understand I am financially responsible for payment in full if no required referral is received by this office. I understand that I am financially responsible for any collection fee and any reasonable attorney's fees and other costs incurred for collection including but not limited to 1 ½ % interest per month on any outstanding amounts unpaid 90 days after insurance resolution. I understand that I am financially responsible for a returned check for any reason and a $25.00 NSF fee.

I understand that I can be terminated from the practice for monetary reasons ***or*** non-compliance with medical advice.

PAYMENT POLICY

The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

MISSED APPOINTMENTS

In order to best serve our patients, we ask for at least 24 hours notice if you are not able to meet an appointment. This allows us to try to fill the appointment time with another patient. If we do not receive this notice, we will charge $87 for a missed office appointment or $174 for a missed surgical appointment. Further Terms & Conditions Provided Upon Request _____

Initial

IF MY INSURANCE CHANGES OR I HAVE NO CURRENT INSURANCE CARD(S) AT TIME OF SERVICE: If I do not have my **current** insurance card(s) for any date of service, I will be billed as a Self Pay. ***Hartsough Dermatology*** might not be able to back date from the time of service to when I do present my **current** insurance card(s) to ***Hartsough Dermatology***. I may be asked to seek reimbursement from my insurance carrier(s).

MEDICARE

Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to ***Hartsough Dermatology***.

NOTICE OF PRIVACY PRACTICES - NPP

I hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that ***Hartsough Dermatology*** has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

PATIENT ACKNOWLEDGEMENT

I have read the Agreement and Authorization form and I understand its contents and that I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of the form and that any statement may not amend to contents of the form. I understand that the records/information released will not be further disclosed for any purpose other than as stated in this Authorization.

_____ _____

PRINT Patient Name Print Name of Authorized Representative

_____ _____ _____

Patient or Authorized Representative Signature Relationship Date

Patient unable to sign. Verbal consent given. Reason: _____