THE SKIN GROUP

PATIENT ACKNOWLEDGEMENT FORM
PLEASE READ THE FOLLOWING INFORMATION CAREFULLY
The Skin Group is referred to as the Practice

Treatment Plans

Our providers may prescribe a specialized treatment plan for your skin condition. This treatment may or may not be covered by your insurance plan. It is possible that an insurance plan may require a referral, a deductible and/or a co-payment for certain treatments.

Financial Policies

We wish to stress that, while we are happy to submit insurance claims on your behalf, financial responsibility for services rendered rests with the patient regardless of the nature or extent of any insurance coverage. Any portion of the insurance carrier's allowable rate for services performed that is NOT paid by the carrier is the responsibility of the patient.

Proof of insurance (insurance ID card) is required at the time of service if you would like insurance to be billed for your visit. If proof of insurance is not available, you will be required to pay for your services in full at the time of your visit.

Many insurance plans include co-payments and deductibles. Co-payments and past due balances are due prior to being seen by the provider. If your plan has a deductible associated with it, payment for services performed is due upon checkout. If any payment is not collected your appointment will be required to be rescheduled until the payment is paid in full.

For procedures that are typically considered "not medically necessary" (skin tag removal, etc.) and, therefore not covered by insurance plans, full payment is due at the time of service. We will be happy to bill your insurance for the service and refund your payment if the service happens to be covered by your insurance carrier.

Interest may be charged on all accounts that are over ninety (90) days or more past due at a rate of 18% per annum.

Wireless Telephone Calls and Email Usage

If at any time you provide a wireless telephone number at which you may be contacted, you consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless you notify the Practice to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the Practice, affiliates, contractors, servicers, clinical providers, attorney or its agents including collection agencies.

If at any time you provide an email address at which you may be contacted, unless you notify the Practice to the contrary in writing, you consent to receiving medical instructions, statements, bills, marketing material for new services and payment receipt at that email address from the Practice.

Office Procedures

We respect our patients' time and make every attempt to stay on schedule. Please understand that delays and emergencies sometimes occur but that we value your time and are doing everything we can to make your visit as efficient as possible. All patients are required to arrive twenty (20) minutes prior to their appointment time. If this policy is not followed your appointment may need to be rescheduled. All no-show appointments will be charged a $25.00 fee which will be non-refundable.

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Based on the nature of your condition and the time constraints placed on the provider, it may be necessary to schedule a procedure on a separate date from your initial office visit. If this is the case and you return for a "procedure only" visit, you will only be charged for the procedure upon return and no office charge will apply.

E-Med Hx Request Consent

By signing this document you are consenting to allow the Practice to download all of your medication history from the pharmacy clearinghouse.

ACKNOWLEDGEMENT of RECEIPT of PRIVACY NOTICE and
Consent for Use or Disclosure of Patient Information for Purposes
Of Treatment, Payment and Healthcare Operations

I hereby consent to The Skin Group, PLLC (the "Practice") using or disclosing my Protected Health Information (PHI) for the following purposes: To provide treatment to me, obtain payment for services given to me or to carry out the Practice's healthcare operations. I also consent to using or disclosing my PHI to another healthcare provider for my treatment, to obtain payment and to carry out that practice's healthcare operations including research studies. I also agree for my PHI to be used for quality assessment and reviewing the competence of healthcare professionals.
I further acknowledge The Skin Group, PLLC, has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my PHI.

I have read and understand the above information:

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

In the case that the nursing staff would need to contact you in regards to lab reports, biopsies or another Personal Health Information (PHI) issue, please check one or more of the following:

_____Work _____Mobile Phone Number

_____Spouse

_____Answering Machine/Voice Mail

Other_____