



YOLANDA C. HOLMES, M.D. P.C.

MEDICAL & COSMETIC DERMATOLOGY

1140 Connecticut Ave NW, Suite 675  
Washington, DC 20036  
P 202-737-6800  
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[www.yolandaholmesmd.com](http://www.yolandaholmesmd.com)

## HIPAA Information and Consent Form

**Yolanda C. Holmes, M.D. P.C. and staff values our relationship with you and takes personal privacy seriously. This Privacy Notice explains how we manage the personal and healthcare information that you have provided and how that information is used. Please read this notice carefully.**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. Please visit [www.hhs.gov](http://www.hhs.gov) for additional information. We have adopted the following policies:

- ✓ Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- ✓ It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- ✓ The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.



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- ✓ You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
- ✓ You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- ✓ Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- ✓ We agree to provide patients with access to their records in accordance with state and federal laws.
- ✓ We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- ✓ You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

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

- ✓ Conduct, plan, and direct my treatment and follow-up. This may include multiple healthcare providers who may be involved in my treatment, either directly or indirectly.
- ✓ Conduct normal healthcare operations such as quality assessments; and
- ✓ View my prescription history from other sources in order to facilitate appropriate medication orders

I understand this practice has the right to change its Patient Privacy Notice and that I may contact this practice at any time to obtain a current copy. I understand that I may request (in writing) restriction or limited use of my health information. I also understand that you are not required to agree to my request, however if agreed, you are obligated to abide with my restrictions.

I may revoke this consent (in writing) at any time, except during which times this practice has already shared information related to my healthcare, in relationship to my signature and date on this consent. By checking and initialing on my demographic form, I acknowledged receipt of, and agreement to this practice's Patient Privacy Notice.

**\*PLEASE CHECK BOX AND INITIAL ON PATIENT DEMOGRAPHIC FORM\***



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## YOLANDA C. HOLMES, M.D. P.C. POLICIES

We want your experience at Yolanda C. Holmes, M.D. P.C. and Yolanda C. Holmes, M.D. P.C. to be pleasant and relaxing. **Please be courteous towards others waiting for appointments by turning sound off cell phones.** Please inform our front desk staff if you have any special needs or concerns and allow us to ensure your time spent with us is a memorable experience. Thank you for choosing Yolanda C. Holmes, M.D. P.C.!

**ARRIVAL:** Check-in with the front desk at least 15 minutes prior to your scheduled appointment to prepare for your appointment. As we are a general dermatology and medical spa, we require that all new guests fill out a brief medical and skin care history and applicable treatment consent forms.

**COSMETIC CONSULTATION:** We are passionate and dedicated to helping you achieve your skincare goals. Towards that end, our physicians offer consultations, \$150, and our Yolanda C. Holmes, M.D. P.C. Clinicians offer consultations, \$75, to better understand your individual needs. Based on a private analysis and conversation, we will design a customized treatment plan that will best meet your expectations.

**PRODUCT RETURNS:** Your satisfaction is our utmost concern. If you are not satisfied with one of your products, please bring us the product, and your receipt, within **two weeks** of the purchase date. We will gladly exchange the full value of the returned product for a product or products that are more suited to your desired result. If you do not wish to have a product exchange, we will be happy to give you a credit towards one of our services or a refund credited back to you in the same method of payment used for purchase.

**PAYMENT:** Yolanda C. Holmes, M.D. P.C. & Yolanda C. Holmes, M.D. P.C. accepts cash, Visa, MasterCard, Discover, American Express, and Care Credit. Payment by check is also accepted. There is an additional \$30.00 fee for returned checks, which will be added to any existing balance. We have financing packages available for several of our cosmetic treatments.

**STANDARD POLICY:** A credit card number is required to secure all appointments, however it will not be charged until the time of your appointment.

**VALUABLES:** We are not responsible for lost or stolen items and encourage you to leave valuables at home.



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**SCHEDULING:** Appointments are **required** for our physicians and clinicians. If we have available Yolanda C. Holmes, M.D. P.C. Clinicians, we will be happy to provide your desired treatment. However, most procedures are booked several weeks in advance.

**LATE ARRIVALS:** Our scheduling is designed to permit the correct amount of time to complete your service. A late arrival will deprive you of precious appointment time. In fairness to others, your treatment must end on time in order to minimize the impact on others. If you are unable to be on time, we will do our best to complete as much of your treatment as possible, however with some treatments, it may be necessary to reschedule you. **If you are 15+ minutes late for your scheduled cosmetic treatment you will be considered a "no-show" and charged a \$75.00 fee.**

**CANCELLATIONS:** Your scheduled appointment is reserved exclusively for you. Should you need to cancel or reschedule your appointment, please notify us 24 hours in advance to avoid a charge for **\$75.00**. All services that are rescheduled or cancelled on the day of the appointment will be charged. **A \$75.00 fee will also be assessed for NO SHOW appointments.**

**FINANCIAL RESPONSIBILITY:** I acknowledge that I am **FULLY RESPONSIBLE** for charges **not** paid by my insurance(s), or any other agency(ies). These charges may include but are not limited to co-pays, total balances and collection fees. These collection fees may include attorney fees, court costs, third party billing/credit reporting costs, and may be based on a percentage at a maximum of 25% of the debt.

**REFERRALS:** I understand that I am responsible for providing a referral, if required, at the time of service. If my insurance denies payment for not providing a referral, I am responsible for all costs.

**INSURANCE:** I hereby authorize Dr. Yolanda Holmes, MD to release information requested by my insurance carrier, or any person, company, or agency responsible for processing claims for my medical services. I authorize direct payment to Dr. Yolanda Holmes by all insurances or any health plan whose benefits are otherwise payable to me up to the full balance of my medical bills.

By checking and initialing on my demographic form, I acknowledged receipt of, and agreement to this practice's policies notice.

**\*PLEASE CHECK BOX AND INITIAL ON PATIENT DEMOGRAPHIC FORM\***