Integrative Dermatology & Laser Spa
Vindhya L Veerula MD, FAAD
(Fort Wayne Integrative Dermatology, Veerula MD,LLC)
www.drvskin.com

Updates to Services & Charges

FINANCIAL AGREEMENT
X_____All FWIM & VeerulaMD,LLC's account balances are due at the time of service. I understand and agree that, (regardless of insurance coverage), I am ultimately responsible for any professional service rendered. I certify that this information is true & correct to my best knowledge. I will notify you of any changes in my insurance coverage, address, or health status. I accept this statement as notice from you that my insurance plan may not pay for any service that you provide to me because the service or procedure may not be covered by the plan or may not be considered medically necessary by the plan. I agree that all services and procedures that I receive from you have been requested by me with full knowledge that my insurance plan may not cover them.

CREDIT CARD CHARGES:
X_____ Due to the rising costs of credit card fees, I understand that a 2% fee will be added to any and all credit card fees, and 1% for debit cards fees. There is no additional fee for payments paid with checks or cash.

COSMETIC TREATMENTS
X_____I also agree that certain treatments are not covered by insurance and are considered cosmetic. These will not be billed to insurance. These require payment IN FULL at the time of, or prior to the procedure. I understand that Dr. Veerula sends all specimens to pathology for verification, and this fee is separate from the removal fee.

LATE PAYMENTS
X_____All past-due account balances may be assessed a LATE PAYMENT FEE equal to 18% per annum on the delinquent balance. A LATE PAYMENT FEE can be avoided by paying the account balance within 30 days of the mailing of the patient statement. Subject to such limitation as may be imposed by applicable law, if I have not made payment on my account as required, my account may be sent to an attorney or collection agency for collection, I will pay the reasonable fees of such attorney or collection agency, and all court costs to the extent provided by law as well as my total outstanding bill. No waiver by Fort Wayne Integrative Medicine or FWIM & VeerulaMD,LLC or any default hereunder shall constitute a waiver of any other default. The construction and enforcement of this Agreement shall be governed by the State of Indiana. Any provision of this agreement that may be prohibited by law shall be ineffective only to the extent of such prohibition. From time to time, FWIM & VeerulaMD,LLC may amend this Agreement by giving of such notice, if any, as may be required by applicable law. FWIM & VeerulaMD,LLC may assign the Agreement, or it's right hereunder, without notice to me.

NO SHOW/CANCELLATION POLICY:
When you make an appointment, we are reserving time in our clinician's schedule that is no longer available to other patients. If you are unable to make it to an appointment, VeerulaMD,LLC requires that you cancel (or re-schedule) your appointment at least 24 hours in advance (excluding weekends and holidays). If you cancel an appointment with less than 24-hour notice or fail to appear in a timely fashion for an appointment, VeerulaMD,LLC will charge the patient $100.00. This applies to new patients as well (government plans are excluded, unless we do not accept your plan). Failure to show for your appointments (or violation of this cancellation policy) on two or more than three consecutive occasions can be grounds for discharge from the clinic . *X _____ If you fail to adequately cancel 3 times, you will be subject to not being accepted for further treatment.*
Note that the cancellation fee may be waived in special circumstances, determined on an individual basis (eg: medical emergency- patients may be asked to provide documentation for the same).

CONSENT TO CARE
X_____ I request and give consent to Dr.Veerula, the nurse practitioners, their associates and assistants who may provide me medical care to perform such medical-surgical care, tests, procedures, and other necessary services as well as provide drugs and supplies as they consider necessary or beneficial for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. In addition, I understand there may be adverse effects or complications from some treatments/procedures/drugs, etc.

Integrative Dermatology & Laser Spa
Vindhya L Veerula MD, FAAD
(Fort Wayne Integrative Dermatology, Veerula MD,LLC)
www.drvskin.com

Check all that apply: I agree to be contacted at: _____Home _____Work _____Cell _____EMAIL

Signature of Responsible Party: _____ Date_____

HIPAA email consent VERY IMPORTANT! PLEASE READ!

HIPAA stands for the *Health Insurance Portability and Accountability Act.* HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information. Information stored on our computers is encrypted

Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email

When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA

The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 – ALLOW UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to VeerulaMD,LLC to send me personal health information via unencrypted email. I also understand that if I send an email to VeerulaMD,LLC, then my consent to receive an email response is provided.

Signature_____Date_____

Printed name (parent or guardian if patient is a minor)_____

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

____ I do not wish to receive personal health information via email

Signature Date_____ Printed name (parent or guardian if patient is a minor)

Please bring completed form to your visit

Please print email address_____

Integrative Dermatology & Laser Spa
Vindhya L Veerula MD, FAAD
(Fort Wayne Integrative Dermatology, Veerula MD,LLC)
www.drvskin.com