Zand Dermatology ◆ Office Policies

*Please **initial** next to each paragraph and sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies*.

_____ (Initials) **RECEIPT OF *NOTICE OF PRIVACY PRACTICES (HIPAA):*** I have been given the opportunity to read a copy of the Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records.

_____ (Initials) **CONTACT PERMISSION:** In the event that Zand Dermatology needs to contact me (patient) regarding an appointment, test result, medication, medical instructions, or any other reason, it is permissible to (check all that apply):

☐ OK to leave detailed message on voicemail. Phone #: _____

☐ OK to send detailed message via text. Cell #: _____

☐ OK to send detailed message via email. Email: _____

☐ OK to speak with spouse/significant other. Name: _____

☐ OK to speak with other family member. Name: _____

_____ (Initials) **CONSENT TO TELEPHONE/EMAIL COMMUNICATION:** I understand that any phone or email communication will be part of my medical record. I also understand that all email and text communication is **not** secure, **not** to be used for any emergent matters, and response will be given back within five to seven business days.

_____ (Initials) **CONSENT TO TREATMENT:** I consent to the performance of examinations, diagnostic procedures, and treatment by Dr. Zand. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

_____ (Initials) **CONSENT TO REFER:** I authorize the staff to release pertinent records to any physician they refer me to for further care. I understand that this office will not use or disclose my medical information without my written authorization.

_____ (Initials) **CONSENT TO PHOTOGRAPH:** I authorize Zand Dermatology to take photographs/videos of me to be used in my medical record, not to be released without my prior authorization.

_____ (Initials) **CANCELLATION POLICY:** If you cancel with less than 24 business hours of the appointment time or do not show without prior notice, a fee of $75 for medical visits and $150 for cosmetic visits will be charged.

Print Patient Name: _____ Date: _____

Signature: _____