

POLLEY CLINIC GENERAL POLICIES

LEGAL GUARDIAN, LEGAL CUSTODIAN, AND POWER OF ATTORNEY

Due to HIPAA regulations, we are not permitted to release any medical information regarding a patient's condition, diagnosis, treatment, or prognosis to anyone without written consent from the patient, legal guardian, legal custodian, or a person with power of attorney for the patient. You may designate individuals who are authorized to obtain this information either by phone or in person in your absence. It is important for our office to have a record of the individuals you authorize.

If you are a legal guardian, legal custodian, or hold power of attorney for the patient, we require a copy of the legal document establishing that status to be on file at Polley Clinic of Dermatology.

As the primary legal guardian, legal custodian, or power of attorney, you may also designate individuals authorized to make healthcare decisions for the patient in your absence. We require both a copy of the legal documentation establishing your status and the completion of this consent form authorizing Polley Clinic of Dermatology to provide treatment for the patient.

I, the primary legal guardian, legal custodian, or power of attorney, hereby grant Polley Clinic of Dermatology permission to treat when accompanied by the adult/s listed below.

Name of Designee	Relationship to Patient
	SELF
	SELF
	SELF

CONSENT TO TREATMENT OF A MINOR 16- AND 17-YEARS OLD: These patients **MUST** have an adult present for an initial office visit, or they will be asked to reschedule their appointment. Patients that are 16 or 17 years old can be seen without a parent or legal guardian only if the parent or legal guardian signs this consent authorizing Polley Clinic of Dermatology to provide treatment for their child, which includes consent for physical exam, biopsy, and freezing treatments. Copay or Deductible amounts, Insurance cards, and Photo ID will be due at the time of visit. Please ensure that the patient and/or authorized person(s) are prepared to pay the amount designated by your insurance company. I hereby grant Polley Clinic of Dermatology permission to treat my 16 or 17-year-old when they arrive at the office accompanied by the adult/s listed below for the initial visit and unaccompanied thereafter.

CONSENT TO TREAT A MINOR: 15 YEARS OF AGE OR YOUNGER: Minors 15 years old or younger **MUST** have an adult present for all office visits or they will be asked to reschedule their appointment. The patient will be seen for their appointment when accompanied by a parent, legal guardian, or other adult with power of attorney on file with Polley Clinic. Any other adult may accompany the patient only if a parent, legal guardian, or other adult with power of attorney has filled out and signed this consent form specifying those adults.

I, the primary legal guardian, legal custodian, or power of attorney, hereby grant Polley Clinic of Dermatology permission to treat when accompanied by the adult/s listed below.

Name of Designee	Relationship to Patient
	SELF
	SELF
	SELF

ADDITIONAL CHILDREN POLICY

Additional guests are not allowed with the patient at their appointment. Children are not allowed to accompany their parents or other patients to their appointment. All parents and patients are informed that no additional guests are allowed to attend the appointment when the appointment is scheduled. This policy is also included in all appointment reminder communications. If patients/parents present with additional children, their appointment will automatically be rescheduled.

Polley Clinic will not be held liable for the safety of any additional children the parents or other patients bring to the appointment. Polley Clinic makes every effort to inform every patient that no additional guests are allowed at the appointment. Law enforcement will be involved in the case of threats to Polley Clinic employees as a result of this policy. This policy is enforced for the safety of all parties, **NO EXCEPTIONS!**

RESTRICTIONS REGARDING PEOPLE IN THE LOBBY AND EXAM ROOMS

For the safety of our patients, we have continued our Covid policy to minimize the number of people in the lobby and exam rooms. Therefore:

1. The patient and one other adult such as a spouse, guardian, or person with the power of attorney will be allowed in the lobby and the exam room.
2. In the case of children under 16 years of age, a maximum of 3 (three) people will be allowed in the lobby and the exam room. This will include:
 - A. The parents and the patient.
 - B. Any adult authorized by a parent and listed on the **CONSENT TO TREAT A MINOR** form.
 - C. Any person vested with power of attorney that applies to the patient.

SOCIAL SECURITY NUMBERS POLICY

Polley Clinic of Dermatology **requires** that your Social Security number be on file with us.

Your social security number may be used as a form of identity verification.

Your social security number is used if your insurance claims are denied. If you are not willing to settle your account, you will be sent to collections.

Your social security number may be used to collect payment for healthcare services.

By law, Polley Clinic is **not required to accept anyone as a patient** and is permitted to have policies that decrease the chance that a patient will not pay their medical bill.

IF YOU DO NOT PROVIDE YOUR SOCIAL SECURITY NUMBER, YOU WILL BE DENIED SERVICE.

CONSENT FOR COMMUNICATION: I understand Polley Clinic of Dermatology will send appointment reminders and information on services by telephone call, email, and text message based on the contact information provided by the patient or the patient's legal guardian, legal custodian, or power of attorney. I understand that I will have the option to opt out of future communications on my behalf or the behalf of my dependents.

UNCONFIRMED APPOINTMENTS POLICY

Polley Clinic requires patients to confirm their appointments within 24 hours of receiving their appointment reminder so that we may prepare for their visit. An automated system sends every patient an appointment reminder by text message, if that information was correctly supplied to us by the patient or the patient's legal guardian, legal custodian, or power of attorney. Appointment reminders are automatically sent 1 week prior to the appointment. These reminders contain an interactive confirmation message that requires you to confirm or cancel your appointment. Unconfirmed appointments will be cancelled, and the patient will have to reschedule. (Business Hours: Monday through Thursday 7 AM to 5:30 PM)

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to Polley Clinic of Dermatology. I understand that I am financially responsible for any balance. I also authorize Polley Clinic of Dermatology and its related companies to release medical information required to process claims and to release my medical record information to provide care. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

PERSON/S AUTHORIZED TO ACCESS YOUR PROTECTED HEALTH INFORMATION (PHI)

Name of Designee	Relationship to Patient
	SELF
	SELF
	SELF

AUTHORIZATIONS: I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that medical treatment may include a review of medical history, a discussion of the reason for the visit, and medical photographs of the area being discussed. I authorize Polley Clinic of Dermatology and its related companies to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those who in Polley Clinic of Dermatology's determination, are required to receive such information for the purpose of medical treatment, quality assurance and peer review.

PAYMENT POLICY: Payment is due at the Time of Service including co-payments, deductibles, and balances due. I understand that I am responsible for all charges for services rendered on my behalf and on behalf of my dependents, less than any amount paid by my insurance to Polley Clinic of Dermatology. As of January 1, 2022, all patient responsible balances that are over 60 days old (2 statement cycles) will be assessed a late fee penalty of \$25.00. Effective September 30, 2026, a 3% surcharge will be applied to all payments made by credit card.

NO-SHOW APPOINTMENT POLICY: We require 24-hour notice of cancellation of your appointment. Should you fail to provide such notice, you will be classified as a NO-SHOW patient, and you will be charged a NO-SHOW fee of \$50. No further services will be rendered until this fee is paid **Three (3) NO-SHOWS in a twelve (12) month period will result in dismissal from the practice by certified mail.**

FORMS PROCESSING FEE: Polley Clinic will charge \$25 for filling out each and every form requested of us by either the patient, insurance company, nursing home or other care facility, pharmacy, medical equipment vendor attorney, other legal entity, or legal guardian. I agree and understand that I am personally responsible for paying all such fees.

PERMISSION TO KEEP CREDIT CARD ON FILE

To Speed you through the check-in process, Polley Clinic of Dermatology can now keep your credit card information stored in our **secure financial database**.

Here are the advantages of allowing Polley Clinic to store your credit card information:

- 1) The receptionist can automatically collect your copayment.
- 2) For patients with high-deductible plans, Polley Clinic can charge the card automatically when insurance has paid its portion of each claim.
- 3) If you have a balance on your account this service will prevent you from receiving a bill or from your account being sent to a collection agency, should it become delinquent.

Type of Card ☐ Visa ☐ MasterCard ☐ Discover Card ☐ American Express

Type Full Name of Card Holder

Cardholder's ZIP Code

Credit Card Number

Credit Card Security Code

Credit Card Expiration Date

PHOTO CONSENT & RELEASE FORM

I the undersigned do hereby agree to allow a staff member of Polley Clinic of Dermatology to take a head shot photo of me for patient identification purposes, I also agree to allow a staff member of Polley Clinic of Dermatology or SkinCureOncology to take photos of all stages of my treatment. They will be placed in my medical record and used to document lesion locations,skin markings, and to monitor my treatment progress. You may also indicate the following preferences for the use of your photos:

- | | | |
|------------------------------|-----------------------------|--|
| ☐ YES | ☐ NO | Education. |
| ☐ YES | ☐ NO | Advertising for Polley Clinic services. |
| ☐ YES | ☐ NO | My identity will remain anonymous. |
| ☐ YES | ☐ NO | My photos will be used for my medical record only. |

CHANGE OF INSURANCE

I attest that one of the following conditions applies:

1. My insurance coverage **has not** changed since my last visit,
2. My insurance coverage **has** changed since my last visit, and I have, **before any further treatment**, notified Polley Clinic of the change and have filled out the **Change of Medical Insurance Notification Form**.
3. If my insurance has changed since my last treatment, and I **have not** reported it to Polley Clinic **before any further treatment**, I understand that I am responsible for any monies not covered as the result of the change.

ALL POLICIES ARE SUBJECT TO CHANGE AT ANYTIME AT THE SOLE DISCRETION OF POLLEY CLINIC AND MAY BE SELECTIVELY ENFORCED AS CIRCUMSTANCES DICTATE. THESE POLICIES TAKE EFFECT AS SOON AS THIS DOCUMENT IS SIGNED BY THE PATIENT OR THE PATIENT'S LEGAL GUARDIAN, LEGAL CUSTODIAN, OR POWER OF ATTORNEY AND ARE REQUIRED TO BE RE-SIGNED ONCE A YEAR.

PATIENT SIGNATORY OR SIGNATORY OF PERSON AUTHORIZED TO SIGN FOR THE PATIENT:

SELF

Name Of Person Authorized to Sign for The Patient

Signature