

# OFFICE POLICIES AND CONSENTS

## A. OFFICE AND FINANCIAL POLICIES

### Notice of Privacy Practices

I have read a copy of the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of any medical information necessary to evaluate and/or treat my condition. I further authorize the release of any medical information necessary to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

### Deposit and Cancellation Policy for Medical Appointments

All medical appointments will require a credit card on file for deposit. It is my responsibility to call the office to cancel or reschedule at least 24 hours prior to my scheduled appointment. Dermatology Center of Northwest Houston reserves the right to charge your credit card a fee of \$25.00 if the appointment is not cancelled at least 24 hours in advance.

### Deposit and Cancellation Policy for Cosmetic Appointments

All cosmetic appointments will require a credit card on file for deposit. It is my responsibility to call the office to cancel or reschedule at least 24 hours prior to my scheduled appointment. Dermatology Center of Northwest Houston reserves the right to charge your credit card for the full service amount if the appointment is not cancelled at least 24 hours in advance.

### Appointment Reminders

I understand that I will receive appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I further understand that I will have the option to opt out of future reminders.

### Cosmetic Retail Sales

Due to the nature of the cosmetic products, no exchanges/refunds are allowed. Therefore, all cosmetic sales are final.

## B. PAYMENT POLICY

**Payment is required at the time services are rendered.** We are allowed by contract with your insurance company to collect your co-payment(s) and/or co-insurance and any unmet deductible at the time of service. For patients with private insurance where we have no contract, you will be required to pay for your services in full at the time of service.

- I understand I will be responsible for any remaining balance not covered by my insurance company, Medicare and/or my supplemental policy. This also includes the full amount of any cosmetic services. Please contact your insurance company to verify benefits and coverage information. We do not file to secondary insurance; Medicare exception, as Medicare files automatically.
- I understand that if I have a surgical procedure or biopsy performed, there are two charges: (1) a charge by the provider for collecting the Biopsy; and (2) a charge to examine the specimen by a Pathologist (who is chosen by my Rendering Provider). I understand that I will be billed separately by the Pathologist (also a medical doctor) who performs the reading.
- I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory I need to use. It is also my responsibility to inform my provider of this at the time services are rendered.
- I understand that a \$25 returned check fee will be assessed to my account for any checks returned by my financial institution.

## C. PATIENT CONSENTS

### Consent for Treatment

I authorize Dermatology Center of Northwest Houston to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. If a biopsy is performed, I authorize the dermatopathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy.

### Consent for Filing Insurance Claims

I understand that in order to file claims and release medical information to any insurance companies I have listed in my financial record, Dermatology Center of Northwest Houston is required to keep my signature on file. I hereby authorize Dermatology Center of Northwest Houston to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize Dermatology Center of Northwest Houston to appeal any denials to my insurance companies on my behalf and authorize the release of any medical information to my Northwest Houston to appeal any denials to my insurance companies on my behalf and authorize the release of any medical information to my insurance companies that is necessary for the processing of claims.

### Consent for Electronic Prescription History

I understand that in order to offer the best patient care, Dermatology Center of Northwest Houston will retrieve my prescription history that has been ordered and filled through Surescripts. I authorize Dermatology Center of Northwest Houston to import the prescription history obtained through Surescripts into my electronic chart.

### Consent for Photos

I understand that in the course of treatment photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members

## D. HIPAA CONSENT FORM

I have read and understand the HIPAA consent form given to me by Dermatology Center of Northwest Houston (Lisa D Hitchins MD PA). I have been given the chance to ask any questions or concerns that I may have at this time. I am also aware that a copy may be provided at my request.

**By signing below, I acknowledge that I have read the above information, have had any questions answered, and certifies my understanding and agreement with the above information.**

Patient Printed Name:		Patient DOB:	
Parent/Legal Guardian Printed Name:		Relationship to Patient:	
Signature:		Date:	