

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

For the purpose of this consent, Dermatologists of Central States (“DOCS”) includes all facilities providing healthcare services, physicians, other healthcare providers and staff of all subsidiaries and affiliates of DOCS.

Consent for Treatment

I consent to the provision of medical treatment, which may include, but is not limited to, routine examination, diagnosis/diagnostic tests and general treatment to be performed by DOCS. I understand that DOCS will explain any examination or treatment, including the anticipated benefits, material risks, and any available alternative therapies including receiving no treatment and that I may ask questions and have those questions answered, to the best of DOCS ability, regarding any such examination or treatment. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment. I understand and acknowledge that qualified medical professionals who are not physicians may perform all or parts of any examinations or treatment and will only be performing tasks that are within their scope of practice. I understand that if further medical examinations, procedure(s) or surgery are required, I may need to sign specialized consents. I understand and acknowledge that notwithstanding this general consent to treatment, I have the right to refuse any treatment, examination, or procedure to the extent permitted by law.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I authorize DOCS to use and disclose my protected health information in order to carry out treatment, payment or healthcare operations. I consent to be contacted about applicable clinical trials. I acknowledge that I have been presented with the DOCS Notice of Privacy Practices which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the Notice prior to signing this consent. I understand that DOCS reserve the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office. An electronic version of DOCS’s Notice of Privacy Practices may be found by visiting our website.

Financial Agreement

I authorize DOCS to bill my insurance carrier and that any payment of insurance benefits be made directly to DOCS. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO) or any other payer. I understand that it is my responsibility to verify with my insurance company if the provider is “in-network” to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.

I understand that self-pay accounts, co-payments, co-insurance, deductibles and non-covered services are required to be collected at the time of service.

I understand that services which are normally covered may be denied in a situation because of certain conditions (for example: non-allowable diagnosis) and I will be responsible for these balances.

I understand that cosmetic procedures are not covered/paid by healthcare plan(s) and I acknowledge that I am responsible for any balance due for such services.

I understand that an outside laboratory is used for pathology services. Billing for pathology services is separate and I am responsible for any balances related to pathology services.

I understand that DOCS may contact me by telephone (including mobile phone), and its affiliates and agents may use a pre-recorded/artificial voice messages and/or an automated telephone dialing system, or by text message or email for any communication related to my account(s). I understand and acknowledge that such communication methods may not be secure.

This is a legal document. By signing, I agree that I understand and accept the terms on this form. I have the right to revoke the authorizations on this form at any time by notifying DOCS in writing, except to the extent that DOCS has already acted in reliance upon them. I acknowledge and agree that such authorizations will remain valid until I revoke them in writing.

Signature of Patient (or Authorized Representative)

Date

Printed Name of Patient (or Authorized Representative)

If Authorized Representative, please explain authority to act on behalf of the Patient