Anne Arundel DERMATOLOGY
and Affiliate Practices

Patient Name: _____

Date of Birth: _____

General Consent/Agreement to Outpatient Services

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients, at least once a year for established patients, and any time there are changes in patient name, address, phone or other insurance information. Ask patients about changes at each visit.

CONSENT TO TREATMENT: I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology (AADerm) entities. I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

FINANCIAL AGREEMENT: I agree to furnish current, valid proof of insurance coverage as well as a copy of my driver's license or other state-issued photo ID at each office visit to confirm my identity and coverage. I will report any changes in insurance or other personal information promptly.

I agree that if I am a parent/ legally authorized representative/guarantor consenting to care and treatment of a minor child, I am responsible for payment and will receive billing statements. Parents are presumed to be legal representatives for their minor children unless legal documents proving otherwise are shared with the office. Please discuss any insurance or custody concerns with the office manager.

I understand that if I do not show up for a scheduled visit and do not notify the office, I will pay a NO SHOW fee of $50.00. If I cancel my appointment in advance, or on the day I am scheduled, my appointment will be rescheduled without a fee. If I repeatedly cancel, a cancellation fee may be charged.

I understand that knowing about my insurance coverage is my responsibility and will contact the insurer for coverage questions. If my carrier requests information from me, I agree to comply promptly with such requests. AADerm is authorized to bill my health plan for the care I receive and I know that payments from my health plan will go directly to Anne Arundel Dermatology. If I should receive the payments, I understand that I will be responsible for paying AADerm. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. In a situation of financial hardship, I agree to contact the billing department to make payment arrangements. I understand that final payment is due upon receipt of my billing statement. I know I can pay outstanding charges by cash or check, credit card, or Care Credit and that there is a $25.00 service fee for returned checks. I understand that past due accounts may be referred to a collection agency. Additional fees may be incurred when accounts are sent to collection and I may be reported to credit reporting agencies. Office visits are at risk of being terminated when non-payment is a persistent, issue.

AADerm will not routinely waive co-payments or deductibles.

I understand that AADerm will hold me financially responsible in any one of the following situations:

a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
c. When my health plan does not participate with AADerm or its providers for the services I want or need and I agree to pay for my care myself. I know that out of network services are charged Medicare allowable rates.
d. When I receive services that are not covered under my health plan including cosmetic services.

If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have AADerm act on my behalf to obtain my benefits when AADerm asks to do so. I also agree that AADerm can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

PATHOLOGY/LAB CHARGES: Pathology and lab charges are billed separately. If your provider elected to send your tissue to the AADerm Pathology Lab or a different pathology lab, you will receive a separate bill from the pathology provider for charges resulting from those services. There are two components to dermatopathology services – the technical component, or TC, which encompasses slide preparation and the professional component, or PC, which encompasses review of the prepared slides under a microscope and professional interpretation of the results. Your detailed bill will outline the components of the service and the specific provider of each service.

CONSENT TO PHOTOGRAPH: I understand photographs, videotapes, digital and/or other images may be made/ recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

ELECTRONIC PRESCRIBING: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to AADerm for the purpose of continued treatment.

MY PERSONAL BELONGINGS: I understand that I am responsible for my personal belongings and valuables.

RELEASE OF INFORMATION: I authorize AADerm practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from or regarding prior encounter(s) at other AADerm practice locations may be made available to subsequent AADerm-affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES to FAMILY and FRIENDS: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for AADerm and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of AADerm. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

Home Phone: _____. Cell Phone: _____

Authorized email address: _____.

OR

(Initials) _____ I decline to receive communication via text.

(Initials) _____ I decline to receive communication via email.

Revocation

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via text

__I hereby revoke my request to receive any future appointment reminders, feedback, marketing, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: Time:

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received/reviewed AADerm's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____ Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative): _____