Island
DERMATOLOGY LLC

HIPAA RELEASE OF INFORMATION

CONTACT PREFERENCE

I prefer to be contacted by:

☐ Cell Phone Number ☐ Email
☐ Home Phone Number ☐ Other: _____

I hereby give permission to Island Dermatology LLC. To notify me by telephone of the following:

☐ Appointment reminder, either by personal/recorded message or text message
☐ A message via voicemail or text to call the office for path/lab results (actual result will not be left)
☐ If path/lab results are benign, a voicemail and/or text message will be left, stating no further treatment would be needed.

I hereby opt into receiving Koru Medical Spa specials/discount via email and/or text messages:

☐ Yes
☐ No

I authorize Island Dermatology LLC to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to myself and those listed below:

Name	Telephone #	Relationship
☐ Emergency Contact	☐ Power of Attorney	☐ Copy of POA paperwork on file
Name	Telephone #	Relationship
☐ Emergency Contact	☐ Power of Attorney	☐ Copy of POA paperwork on file

ASSISTED LIVING/LONG TERM FACILITY CARE RESIDENTS

Power of Attorney: _____

Name Telephone # Relationship

☐ Copy of POA paperwork on file

Please list any facility personnel we are allowed to speak with on your behalf regarding your medical information:

Name Telephone # Facility Personnel Title

ALL PATIENTS

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other health care providers associated with my care to facilitate further heath care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

Patient Printed Name Patient Signature Date

Island
DERMATOLOGY LLC

75-5995 Kuakini Hwy, Suite 443
Kailua Kona, HI 96740
Phone (808) 323-2608 Fax (808) 885-9793

CONSENT TO CLINICAL PROCEDURES

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), or other services rendered during my visit with Island Dermatology LLC.

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns and goals with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges.

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly.

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be thoroughly discussed with you by your physician if it is a potential during your procedure.
- I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record. They may also be sent to your family physician and/or referring physician. They will not be used for any other purpose without a proper consent.

If a complication after the procedure would arise, there may be a charge for the medical management that will be submitted to your insurance company. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Island Dermatology LLC. I do not impose any limitations on Island Dermatology LLC and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

_____ _____

Patient Printed Name Patient Signature / Date

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or Guardian Printed Name Parent or Guardian Signature / Date

_____

Relationship to Patient

Island
DERMATOLOGY LLC

75-5995 Kuakini Hwy, Suite 443
Kailua Kona, HI 96740
Phone (808) 323-2608 Fax (808) 885-9793

PATIENT FINANCIAL POLICY

Welcome and thank you for choosing Island Dermatology LLC for your dermatology care. Your clear understanding of your **Patient Financial Policy** is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

Insurance: When making an appointment with your physician, it is **your responsibility** to confirm with your insurance company that the physician is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral at the time of your appointment. If you do not have your referral at the time of your appointment or do not have active insurance, you will need to reschedule your appointment or choose to be seen **without the insurance benefits and pay for your visit in full**.

You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 90 days from the date the claim is filed for the insurance company to pay. If the insurance company does **NOT** pay within this time, **you will be** responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered service, co- insurance, coordination of benefits, or pre-existing conditions. You are responsible for all co-payments and deductibles **at time of service**.

Check-In: Please bring your current insurance card and government issued photo ID with you to **EACH** visit. Without the insurance card, we will be unable to file your insurance, and **you will be responsible** for all charges for that visit. On follow-up visits you will be asked to verify all demographic and insurance information so that our records remain up to date.

Check-Out: Please be **prepared to pay** for the current visit as well as any past balances on your account. Payment and copayments, deductibles, or fees for non-covered services will be required at the time of service. For your convenience we take cash, check, and all major credit cards.

No-Show Policy: You are responsible for notifying us if you are unable to make your appointment. If your appointment is not cancelled at least **24 hours in advance** you will be charged a **$50 fee**. If your appointment is for a surgical procedure and is not cancelled at least **48 hours in advance** you will be charged a **$100 fee**. This fee will not be covered by your insurance company and must be paid in full before we allow you to schedule your next appointment. After three no-shows a patient may be discharged from the practice.

Late Policy: If you are late to your appointment our Providers will need to move on to see other patients that have arrived for their scheduled appointments. If you choose, you may wait until there is a break in the schedule to be seen, however, there is no guarantee on when that would occur. You also have the option to re-schedule your appointment for a later date.

Non-Covered Services: An **Insurance Waiver** may be required to acknowledge understanding of your responsibility for **paying for non-covered services**. In dermatology, there are many procedures that are considered by Medicare and private insurers as **non-covered**, including removal of skin tags, cosmetic treatment of spider veins, removal of whiteheads, as well as others. If you are coming in for a non-covered service, please be prepared to pay for the service **in full**.

Return Check Fees: Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a **$25.00 fee per check**.

Pathology Fees & Lab Tests: If your visit includes biopsies or lab tests these specimens are sent out for processing. You will receive separate billings from the laboratory performing the service. For service quotes or billing inquiries please contact your laboratory, we are unable to provide you with this information since they are a separate entity.

ACKNOWLEDGEMENT OF RECEIPT

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice by requesting a copy or reading a copy located on our website.

By signing below, you acknowledge you have read, understand, and agree to the Island Dermatology LLC's Patient Financial Policy and our Notice of Privacy Practices.

_____ _____

Patient Printed Name Patient Signature / Date

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or Guardian Printed Name Parent or Guardian Signature / Date

_____

Relationship to Patient