MacInnis Dermatology – Consent Form

Please initial and sign at the bottom

_____ Initials	**Consent for treatment –** I voluntarily consent to receive medical and health care services by Dr. Colleen MacInnis and/or her associates that may include examinations, routine office procedures, diagnostic procedures, and other treatments deemed necessary by Dr. MacInnis. I I agree to communicate any questions or concerns about my treatment to Dr. MacInnis prior to being treated. I agree to inform Dr. MacInnis before services are rendered about any health problems I may have, possible drug allergies, current medications I am taking, or any other information that may be pertinent to my treatment.
_____ Initials	**Team Approach to Treatment – I understand that at MacInnis Dermatology we have a Certified Physician's Associates (PA-C) and Advanced Practice Registered Nurse (APRN) on staff. The relationship between a PA-C, APRN and the supervising physician is one of mutual trust and respect. The Physician's Associate and Nurse Practitioner is a representative of the physician, treating the patient in the style and manner developed and directed by the supervising physician. The physician PA-C, and APRN practice as members of a medical team in the delivery of medical care.**
_____ Initials	**No Guarantees –** I understand that the practice of medicine is not an exact science and results vary among patients. I understand there is no contract, warranty, guarantee or promise concerning the results of medical services provided by Dr. MacInnis and/or her associates.
_____ Initials	**Limited Release of Information –** I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.
_____ Initials	**Assignment of Benefits –** I authorize MacInnis Dermatology to accept assignment/payment from my insurance carrier(s) for services rendered. I authorize use of my signature below on all my insurance submissions.
_____ Initials	**Pathology Services for non-Medicare patients –** I authorize Dr. MacInnis and/or her assistants at MacInnis Dermatology to send my tissue or other specimens to CarePath DX or other laboratories for microscopic slide processing and interpretation. I authorize representatives of MacInnis Dermatology to bill my insurance carrier for all pathology services performed by outside laboratories.

****HIPAA POLICY**** - Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of MacInnis Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.** Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA form.

<u>If no one will be added, please print NONE</u> (We will speak with you and **ONLY** you)

HIPAA	Emergency Contact	NAME	Contact number	Relationship

I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

Patient Signature: _____ ***Date :*** _____/_____/____

MacInnis Dermatology - Financial Policy

I understand and agree to the following terms of MacInnis Dermatology's financial policy:

- Payment is due in full at the time of service for self-pay patients and for cosmetic procedures.
- We bill insurance as a courtesy, and balances are ultimately the patient's responsibility. If we cannot collect insurance payment within 90 days, the balance will be assigned to the patient.
- Co-payments and co-insurance (where a percentage of charges is assigned to the patient) are due at the time of visit. Two copays may be assessed for MOHS if two providers are needed for your procedure.
- Patients must provide proof of insurance at the time of visit. If the patient's insurance card is not presented when there is a change in coverage, the patient will be responsible for full payment at the time of service.
- Patients are responsible for knowing their insurance coverage and benefits. Although we make every attempt to accurately confirm our participation in various plans, it is ultimately the patient's responsibility to verify coverage. We recommend calling your insurance carrier prior to your visit to verify coverage. Rejection of all or part of your medical insurance claim by your insurance company does not relieve your financial obligation to MacInnis Dermatology.
- Payment for patient bills is due upon receipt. After we receive insurance payment, there may be a remaining patient balance for deductibles, additional co-payments, non-covered services or any other charge the insurance carrier may assign to the patient. Payment is due immediately upon receiving a bill from MacInnis Dermatology.
- Prior balances are due at the time of visit. Returning patients must pay their bill if they arrive for an appointment and have an outstanding balance on their account.
- Accounts not paid within 120 days will be sent to a collection agency and may be subject to additional fees.
- Missed appointments are subject to forfeit of deposits, consult fees and a cancelation fee as follows: $75 for patient appointments, $100 for aesthetic appointments, and $150 for surgical appointments. Please provide at least 24-hours advance notice if you need to reschedule or cancel your appointment.
- MacInnis Dermatology accepts cash, checks and all major credit cards. If a check payment is returned by the bank, a $35.00 fee will be applied to the patient's account. Patients who have a returned check must use cash or credit card only for all future payments.

_____	_____	_____/_____/_____
Patient or Responsible Party Signature	**Print Name**	**Date**