NORTH FLORIDA DERMATOLOGY

Consent and Authorization Form

I. **Authorization for Medical Care:** I consent to any Care that may be considered necessary and/or advisable in the judgment of my Healthcare Provider. I understand that my Healthcare Provider is an employee of North Florida Dermatology. I consent to having photographs taken of me in the course of and related to my Care and to the use of such photographs and my medical data for treatment and educational purposes. I understand that my physician may access my medical information from a variety of sources, including information about my medication use that comes from electronic prescribing software and databases. **Telemedicine**. I understand and agree that my Healthcare Provider may utilize telemedicine (the electronic communication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs as part of my Care. Except in emergency circumstances, my Healthcare Provider will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek Care elsewhere in lieu of a telemedicine encounter.

II. **Risk Management and Dispute Resolution:** I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my Care) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of North Florida Dermatology for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both of these entities.

III. **Release of Medical Information:** I authorize North Florida Dermatology to release information from my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests) and any other information that may be required to secure payment for charges incurred by me or on my behalf to: (1) any North Florida Dermatology affiliated provider; (2) my referring physician; (3) the guarantor on my accounts; (4) any Third Party Payor (including, but not limited to, Medicare, Medicaid, Tri-care, governmental programs, health, accident, automobile, or other insurance, worker's compensation, HMO (commercial, Medicaid, Medicare), self-insured employers and any other sponsors who may contribute payment for Care) that contributes payment for my Care. In addition, I authorize the release of any information to county, state, or federal public health agencies, as required by law.

IV. **Assignment of Benefits and Responsibility for Payment:** I assign to North Florida Dermatology payment from any Third Party Payor with whom I have coverage or from whom benefits are or may become payable to me, for Care I receive (past, present, or future). I agree to be personally responsible for payment of any Care that is not covered by a Third Party Payor, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

V. **Guarantor Agreement:** By signing this form, I agree that all charges connected with Care not covered by any Third Party Payor are due and payable by me at the time the Care is rendered or at the discontinuation of Care. If the insurance information I have provided is not active at the time of Care, I will be responsible for any balance due at the time the Care is rendered. The charges I agree to pay are those listed in North Florida Dermatology's current fee schedule (which is available for inspection upon request) as modified by any applicable contract North Florida Dermatology may have with a Third Party Payor. I understand that billing statements will be sent to the patient to whom the Care has been

rendered and the guarantor is responsible for payment. I acknowledge that, unless the North Florida Dermatology and my Third Party Payor have agreed that I will not be billed, if North Florida Dermatology has agreed to bill my Third Party Payor, it has agreed to do so as a courtesy and that North Florida Dermatology has the right to demand payment in full from me at any time prior to full payment from any Third Party Payor. If an overdue account is referred to collections, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with the collection process. I consent to North Florida Dermatology or any third party contacting me by telephone, including my cellular phone, for purpose of collecting any amounts owed by me. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a judgment is entered against me for collection of charges I have agreed to pay.

VI. **Agreement to Pay for Professional Component of Pathology Services**: When a specimen of my skin, tissue, blood, urine, stool, or similar material is tested, the testing will be performed under the supervision of a pathologist at a separate facility. I understand I will receive a bill from the pathologist for these services for each test. By signing this document, I agree to be responsible for the pathologist's bill to the extent that payment is not provided by my Third Party Payor.

VII. **Agreement to Mediate:** In accepting Care at North Florida Dermatology, I agree that before I file any lawsuit against North Florida Dermatology or any of its providers, employees, or agents, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party person who has been certified to be a mediator tries to help settle claims. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

I acknowledge that I have been provided a copy of the Consent and Authorization Form and I have read and understand its contents. I understand that I may ask questions regarding the Consent and Authorization Form and I may request a copy of this document at any time.