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**CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

(Complete every 2 years)

**\*PLEASE INITIAL EACH LINE ITEM**

**Consent for Treatment**

\_\_\_\_\_ I give my permission for the providers and staff of The Skin Firm to treat me as deemed necessary in the exercise of their professional judgment.

\_\_\_\_\_ I understand that medical care requires my cooperation, and I will follow my provider's orders and prescriptions. If indicated, I will make and keep appointments for follow up care and call the office to note any changes or concerns in my condition.

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

\_\_\_\_\_ I authorize The Skin Firm 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 Skin Firm’s 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 The Skin Firm reserves 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 The Skin Firm's Notice of Privacy Practices may be found by visiting our website.

**Financial Agreement**

\_\_\_\_\_ I authorize The Skin Firm to release any information to third party payers (including Medicare), including the diagnosis and the records of any treatment or examination rendered to me or my dependent(s) during the period of such medical care.

\_\_\_\_\_ I understand I may be billed by an outside laboratory for laboratory and/or pathology services performed in this office in accordance with the terms of my insurance plan as determined by my insurance company.

\_\_\_\_\_ I authorize and request that my insurance company, and/or third-party payer, in lieu of reimbursing me directly,

pay to the provider or medical group any benefits for services rendered. 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 cosmetic procedures are not covered/paid by health care plan(s) and I acknowledge that I am responsible for any balance due for such services. A deposit may be required for some procedures. Additionally, this deposit may be forfeited if you no-show without the appropriate 24-hour notice. All payments for cosmetic services and/or products must be made using cash or credit card. Personal checks are not accepted for cosmetic procedures or products.

\_\_\_\_\_As a guarantor, I agree that I am financially responsible for all services rendered to me and my dependent(s). I understand that self-pay accounts and non-covered services are required to be collected at the time of service. I understand that my medical insurance company may pay less than the actual amount billed for services provided. I agree to pay all deductibles, coinsurance, and/or co-payments as determined by my insurance, as well as the charges for any medical care or supplies that are not covered under the terms of a medical insurance plan. All such payments are due at the time of service. In the event there is a balance due after my claim is processed, I acknowledge I will receive a billing statement that requires full payment. Any accounts that are 90 days past due from the date of service with no recent payments or an established payment plan will be referred to an outside collection agency. I understand that a scheduling block may be placed on my account if it is referred to collections and I must make payment arrangements prior to scheduling any further appointments. Reasonable costs of collection and/or attorney fees may be added to the amount due on my account. I can contact The Skin Firm at (740)208-2550 anytime with questions.

\_\_\_\_\_Cancellations and changes to appointments should be made as soon as possible. If you fail to show up for your assigned appointment without canceling 24 hours in advance:

* A $25 no-show fee will be charged for missed general appointments
* A $50 no-show fee will be charged for missed cosmetic/aesthetic appointments
* A $125 no-show fee will be charged for missed surgical appointments

\_\_\_\_\_Releasing of medical records is available at a fee dependent upon chart volume. Medical records may be sent to another provider at no charge. Insurance, disability, applications forms, etc. will be a minimum charge of $10 payable in advance.

\_\_\_\_\_**Methods of payment accepted are**: Cash, Visa, MasterCard, Amex, Discover and personal checks (not cosmetic) with proper identification are accepted. A $30 overdraft charge will be added to any insufficient funds amount on any returned check.

**\_\_\_\_\_Auto Pay and Credit Card on File:** The Skin Firm securely stores an updated credit card on file for all patients.

This information is stored securely with the same HIPAA-compliant software that protects your confidential medical information. Should you have a balance after we have received your insurance response, you will receive a statement from The Skin Firm and your credit card on file will be charged for the remaining balance 10 days after the statement is issued.

\_\_\_\_\_I understand that The Skin Firm may contact me by telephone (including mobile phone), and its affiliates and agents may use a pre-recorded/artificial voice message 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. In return for allowing The Skin Firm to contact me, The Skin Firm will not release, sell, or otherwise distribute to any other person or entity any contact information that I provide without my express written authorization.

**I hereby certify that I have read the foregoing Consent and fully understand and agree to the consents thereof. I have had the opportunity to ask any and all questions I may have, and any questions I have asked were answered to my satisfaction. 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 The Skin Firm in writing, except to the extent that The Skin Firm has already acted in reliance upon them. I acknowledge and agree that such authorizations will remain valid until I revoke them in writing.**

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Patient Name or Legal Guardian/Patient Representative (PRINT) Date

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Signature of Patient or Patient’s Legal Guardian/Representative Date

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