# DILWORTH

DERMATOLOGY & LASER

*Patient Intake Forms · Please print, complete, and sign each form, and bring them with you to your first appointment.*

## Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, at any time in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Dilworth Dermatology and Laser to release my records and any information requested to the following individuals:

| | |
|---|---|
| 1. Name | Relation to Patient |
| 2. Name | Relation to Patient |
| 3. Name | Relation to Patient |
| 4. Name | Relation to Patient |

### Authorization Regarding Messages

(please check all that apply)

- ☐ I authorize you to leave a detailed message on my home or cell number regarding appointments
- ☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
- ☐ I authorize you to leave a message with anyone who answers the phone
- ☐ Messages may only be left with: _____

| | |
|---|---|
| Patient Name (please print) | Date |
| Patient Signature | Relationship to patient |

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# Office Policies

## 1. Cancellation / No-Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly full appointment book.

If an appointment is not cancelled at least 24 hours in advance, new patients will be charged a fifty-dollar ($50) fee and established patients will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

## 2. Scheduled Appointments

We understand that delays can happen; however, we must try to keep the other patients and doctors on time. If a patient is more than 15 minutes past their scheduled time, we will have to reschedule the appointment.

## 3. Cancellation / No-Show Policy for Appointments of 30 Minutes or Longer

Due to the large block of time needed for certain appointments, last-minute cancellations can cause problems and added expenses for the office.

If appointments that last longer than 30 minutes of scheduled appointment time are not cancelled at least 3 days in advance, you will be charged a seventy-five-dollar ($75) fee; this will not be covered by your insurance company.

## 4. Account Balances

Payment is due when services are rendered. Should you have questions about your bill, please call and ask to speak with a billing office representative.

A late fee equal to 30% of the account balance will be applied to any account that is referred to a collection agency. Patient accounts that have been referred to a collection agency twice within a 12-month period of time will be dismissed from our practice.

| Patient Name (please print) | Date |
| --- | --- |
| Patient Signature | Relationship to patient |

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# Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

Patient Name _____ Date _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information.

I understand that Dilworth Dermatology and Laser may use or disclose my protected health information for treatment, payment or healthcare operations — which means for providing healthcare to me, the patient; handling billing and payment; and taking care of other healthcare operations. This may include releasing your name, phone number and/or email address for the purpose of contacting you regarding appointments and practice updates. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

Dilworth Dermatology and Laser has a detailed document called the “Notice of Privacy Practices.” It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the “Notice” before signing this agreement. If I ask, Dilworth Dermatology and Laser will provide me with the most current “Notice of Privacy Practices.”

My signature below indicates that I have been given the chance to review such a copy of the “Notice of Privacy Practices.” My signature means that I agree to allow Dilworth Dermatology and Laser to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I have the right to revoke this consent in writing at any time, except to the extent that Dilworth Dermatology and Laser has taken action relying on this consent.

You may obtain a copy of our “Notice of Privacy Practices” at any time by contacting: Office Manager, Dilworth Dermatology and Laser, (704) 376-9849.

Signature (Patient or Legal Custodian / Representative) _____ Date _____

Relationship to patient _____

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# Consent for Medical Treatment

**Consent for Medical Treatment:** I am asking for care and I agree to be given all necessary diagnostic tests, examination, and surgical and medical treatments prescribed by the physician/provider treating me.

**Authorization for Release of Medical Information:** I give permission to release medical information about my treatment (including copies of my medical records) needed for payment of my insurance claim or for my continuing care after I have been treated. I reserve the right to revoke this consent at any time, and I understand that any revocation will be effective no earlier than the date of my notice.

**Authorization to Pay Benefits to Physician:** I authorize and request payment of my medical benefits directly to my physician. This authorization will cover all medical services rendered until a written notice of cancellation is received in this office.

I understand that the amounts paid by my insurance company to my physician for specific services rendered may change from time to time and that any payment amounts requested at checkout or insurance adjustments appearing on my visit summaries and statements are estimates. As such, upon receiving final accounting and payment from my insurance company, an additional payment may be required of me to settle my account.

If I am on Medicare, I certify that I have given correct information on my application for payment under Title XVIII (Medicare) of the Social Security Act. I ask that any authorized Medicare benefits be paid on my behalf for services furnished to me by my provider. I give permission to release any of my medical information or any other information needed by Medicare and their respective agents, in order to determine the benefits to which I am entitled.

**Financial Agreement:** I understand that if my insurance is not in network with Dilworth Dermatology and Laser that payment is expected at the time of service. I understand that it is my responsibility to obtain the necessary approval for the doctor's services, if my insurance requires precertification for those services. I understand that I am financially responsible for the amount of my bill which may include a deductible set by my insurance carrier and/or charges NOT covered by my insurance. I understand that I am financially responsible for the cost of any laboratory or pathology services necessary for diagnosis and treatment. Any lesion removed will be sent to Ball Dermpath for pathology testing. Orders for laboratory specimens are sent to LabCorp. I understand that I am financially responsible for any lab testing necessary for diagnosis and treatment if my insurance carrier is not in network with LabCorp.

| Patient or guardian signature | Relationship to patient | Date |
|---|---|---|