Dermatology and Skin Care ASSOCIATES, P.C.

Rashel Goodkin, MD, FAAD
Rebecca O'Sullivan, MD, FAAD, FACMMSCO
Pamela Weinfeld, MD, FAAD, FASDS

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

By my signature below, I voluntarily give my informed consent for myself and/or my child to be examined and treated by the physicians and staff at Dermatology and Skin Care Associates, P.C. ("the Practice"), including medical evaluation, treatment, and related procedures that are necessary in the judgment of the Practice. I acknowledge that no guarantees have been made to me concerning the results of outcomes of evaluations, tests, treatments, or procedures. I understand that the Practice may find that additional evaluations, tests, or procedures are necessary for my care. I understand that I am ultimately responsible for following the instructions of the Practice and for having any recommended evaluations, testing, or procedures performed. I understand that by signing this form, I am authorizing the Practice to treat me for as long as I seek care from the Practice, or until I withdraw my consent in writing.

By my signature below, I hereby assign to the Practice the right to receive payment of benefits for any service rendered to me by the Practice. I understand that I am financially responsible to the Practice for services I receive which are not covered under my health insurance. I hereby certify that the information given by me in applying for payment under any State or Federal health care program (including but not limited to Medicare and Medicaid) or submitted by me to my insurance carrier(s) is complete, accurate, and correct.

Patient Signature ______________________________ Date ______________________________

Parent/Guardian Signature ______________________ Relationship to Patient ____________________

INSURANCE WAIVER DUE TO LACK OF VALID REFERRAL

Your insurance company may require that you obtain a valid referral/authorization from your primary care physician for the service we are providing you, today and/or in the future. It is your responsibility to obtain a valid referral prior to or WITHIN 60 DAYS of each visit, whenever it is required by your insurance company. Many insurance companies will permanently deny payment if the proper referral is not received within 60-90 days.

In the event of insurance denial(s) of the claims filed on your behalf due to lack of a valid referral, you are responsible for any/all balances due. Please print and sign your name below indicating that you are aware that in the event that your insurance company requires a referral/authorization on file for services provided to you by our practice, and you do not obtain a timely/valid referral/authorization, that you understand your financial responsibility for charges.

Patient Signature ______________________________ Date ______________________________

Parent/Guardian Signature ______________________ Relationship to Patient ____________________

Please read both sides carefully. You will sign on a separate signature page to acknowledge receipt of each policy.

(over)

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES AND CONSENT TO DISCLOSE HEALTH INFORMATION

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Policies for the Practice. I hereby consent to the Practice's disclosure of my medical information for treatment, billing, and health care operations (collectively TBO). Unless I instruct otherwise in writing, I also consent to the Practice's disclosure of my medical information on my home answering machine/ voicemail or cell phone voicemail and to my spouse/partner, children, and other family members.

I understand that my medical record contains or may contain in the future information classified as highly confidential. By my signature below, I specifically consent to the disclosure of such information for TBO purposes, including: information about genetic testing; information about venereal disease(s); information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor, or other allied mental health professional or human service professional; information about family planning services, abortion consent form(s) or mammography records; if I am an emancipated minor, information about my treatment and diagnosis (except to my parents); and information about research involving controlled substances.

If I do not wish such highly confidential information to be disclosed, I will specify that in writing to the Privacy Officer at the Practice. I will need to sign separately for the release of information about HIV/AIDS status or treatment for substance abuse (alcohol or drug).

Patient Signature ______________________ Date ______________________

Parent/Guardian Signature ______________________ Relationship to Patient ______________________

CREDIT CARD POLICY

It is the policy of this office to obtain from you today a valid credit card number in the event of an unpaid balance on your account. You can be assured that your credit card information will be held securely, and only utilized for non-covered services, unmet deductibles, and co-payments. Before we bill your credit card, we will mail one bill to your address allowing you the opportunity to question or dispute the charge, and to pay conventionally through the mail. Your credit card will only be charged if there is no response to our bill.

Patient Signature ______________________ Date ______________________

Parent/Guardian Signature ______________________ Relationship to Patient ______________________

CANCELLATION POLICY

A fee will be charged for any missed appointment if 24 hours notice is not given, unless acceptable documentation of an emergency is provided.

Patient/Guardian Initial: ______

Please read both sides carefully. You will sign on a separate signature page to acknowledge receipt of each policy.

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