Consent Form

Patient Label

dermatology CONSULTANTS

Preferred Name:_____

The Health Insurance Portability and Accountability Act (HIPAA) requires Dermatology Consultants to obtain your authorization to allow communications regarding your protected health information (PHI). This authorization allows Dermatology Consultants to discuss your health care with a person that you designate, leave recorded messages at your home, work, or on your cell phone related to your medical care and treatment, payment, appointment status, or follow-up and send electronic messages via the patient portal related to your medical care and treatment, payment, appointment status, or follow-up.

List phone number(s) <u>in order of preference</u> for receiving appointment reminder and/or patient care calls:

<u>Check messaging preferences below</u>:

1. Preferred Daytime Number_____
   - ☐ no message
   - ☐ message to call
   - ☐ detailed message

2. Secondary Phone Number_____
   - ☐ no message
   - ☐ message to call
   - ☐ detailed message

<u>Email Preferences: for new patients or changes to current preferences only:</u>

- ☐ Yes, please send me a patient portal invitation and contact me for news and events in our practice.
- ☐ No, I do not want to provide my email or participate in the patient portal.

Email: _____
(We will not share your email address.)

<u>Outside Prescription History</u>

- ☐ Yes, you may upload my prescription information from outside providers.

This authorization allows Dermatology Consultants to discuss <u>all aspects</u> of my PHI with the individual(s) listed below:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

<u>Power of Attorney</u> - financial and property (provide documentation)**:**

Name:_____ Relationship:_____ Phone:_____

<u>Health Agent</u> - healthcare decisions (provide documentation):

Name:_____ Relationship:_____ Phone:_____

DOB:_____ Address:_____

Please initial each line item and sign below.

Initial:_____ Records Release: I authorize the release of my health information by Dermatology Consultants, P.A. for the purposes of my current treatment, including release of information to my referring or primary care provider and other health care providers participating in my current treatment, or as otherwise necessary for Dermatology Consultants, P.A. to provide treatment to me. I authorize the release of medical information (including billing information) as necessary for payment purposes, including release by Dermatology Consultants, P.A. to my insurance company, the responsible party named above, and any other person or entity responsible for payment for my medical treatment. I authorize the release of my health information to business associates of Dermatology Consultants, P.A. as necessary for the purposes of
Dermatology Consultants, P.A.'s health care operations.

Initial:_____ Assignment of Benefits: I authorize payment of medical benefits to Dermatology Consultants, P.A. for services rendered to myself and/ or dependent, includes both in-office and virtual care. **Patients without Insurance:** If you do not have insurance, or your insurance company does not cover your services, we require that you make a down payment of $100.00. This is not payment in full, and you will be responsible for all charges accrued on your account. Your $100.00 down payment will be applied as a payment on your account and you will be billed for the remaining amount due. A down payment of $250 is required for Mohs surgery.

Initial:_____Telehealth Consent: I understand that my healthcare provider may render services via telehealth technology. Visit types may include two-way interactive video or store-and-forward technology. My health care provider has explained how the telehealth technology will be used to affect such a consultation. Potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
My healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the telehealth video conferencing connections are not adequate for the situation. If others are present during the consultation, they will maintain confidentiality of the information obtained, I will be informed of their presence.

Initial:_____Health Information Exchange (HIE): The Health Information Exchange (HIE) allows participating healthcare organizations to electronically exchange your patient health information during and as a part of your care and treatment. Your privacy and the security of your personal information is important to us. Any facility that uses our HIE is subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). You may decline or "opt-out"; If you decide to decline or "opt-out," your health information will not be available for electronic exchange or sharing except in cases of emergency or where required by law. This decision only applies to the HIE and does not include standard healthcare uses and disclosures for treatment, payment and operations.

☐ **Yes, you may include my health information** ☐ **No, I prefer to opt-out**

<u>For Medicare recipients only</u>:

Initial:_____ Medicare Authorization: I request that payment of authorized Medicare benefits be made on my behalf to Dermatology Consultants, P.A. for any services furnished to me by that physician / clinic / supervisor. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Initial:_____MEDIGAP: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for related services.

I have read or had this form read and/or had this form explained to me. I fully understand its contents. I have been given an opportunity to ask questions and any questions have been answered to my satisfaction. I understand I may refuse to sign this authorization and realize this may result in a delay of treatment and/or have potential adverse health consequences. This authorization will expire in one year from the date signed; however, I may change or revoke it at any time by contacting Dermatology Consultants.

Signature of Patient or Legal Representative **Print Name** **Date**

Updated: 04/18/2023