

# Ideal Dermatology

## HIPAA and No-Show Policy/Financial Responsibility Consent Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **HIPAA Acknowledgement:**

I acknowledge that I have received/have access to the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health care information for treatment, payment, health care operations, and other described and permitted uses and disclosures.

### **Protected Health Information Consent:**

I give permission for my Protected Health Information (PHI) to be disclosed for purposes of billing and payment as well as communicating results, findings, and care decisions to the people designated below. Information will not be released without authorization, even to family members. I agree that the practice may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes. I authorize Release of PHI to:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

### **No-Show Policy:**

Appointments canceled in less than 24 business hours will be marked as a No-Show. No-Show appointments will be charged a **\$50 (\$300 for Mohs or Surgeries)** fee and may be discharged from the clinic after two No-Show appointments.

### **Financial Responsibility Policy Assignment and Release:**

1. I have insurance coverage and assign all medical benefits, if any payable to me for services rendered.
2. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
3. I authorize the use of this signature on my insurance submissions.
4. I am aware it is my responsibility to contact my insurance company to verify that it will pay for charges incurred and I understand that I am financially responsible for all charges not paid by insurance.
5. I am aware that Pathology and Lab services may be billed separately.
6. Procedures may result in additional charges.
7. I authorize charges for fees and balances.
8. **For your convenience, Ideal Dermatology securely keeps a card on file, which may be used for no-show or late cancellation fees, and balances after insurance pays.**

If you do not have insurance or are choosing not to use insurance:

*I understand that I DO NOT have or do not wish to provide my medical insurance for claim and I will be billed as a SELF PAY patient for all services rendered.*

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Legal Guardian of Patient