DOCS
DERMATOLOGY GROUP

For the purpose of this consent, DOCS Dermatology Group ("DOCS") includes all facilities providing healthcare services, physicians, other healthcare providers and staff of all subsidiaries and affiliates thereof.

CONSENT FOR TREATMENT

I consent to the provision of medical treatment which may include, but is not limited to, routine examination, diagnosis/diagnostic tests and general treatment to be performed by DOCS. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment. I understand that if further medical procedure(s) or surgery is required, I may need to sign specialized consents.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I authorize DOCS to use and disclose my protected health information in order to carry out treatment, payment or healthcare operations. I acknowledge that I have been presented with the 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 DOCS reserve 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 our Notice of Privacy Practices may be found by visiting our website.

FINANCIAL AGREEMENT

I authorize DOCS to bill my insurance carrier and that any payment of insurance benefits be made directly to DOCS. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO) or any other payer. 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 acknowledge and understand that I am responsible for payment of all self-pay accounts, co-payments, co-insurance, deductibles, and any non-covered services at the time of service, in accordance with my health insurance plan. I understand that services which are normally covered may be denied in a situation because of certain conditions (for example: non-allowable diagnosis) and I will be responsible for these balances.

I understand that cosmetic procedures are not covered/paid by healthcare plan(s) and I acknowledge that I am responsible for any balance due for such services.

I understand that an outside laboratory is used for pathology services. Billing for pathology services is separate and I am responsible for any balances related to pathology services.

I understand that DOCS may contact me by telephone (including mobile phone), and its affiliates and agents may use a pre- recorded/artificial voice messages and/or an automated telephone dialing system, or by text message or email for any communication related to my account(s).

As part of this financial policy, I authorize DOCS to maintain my credit card information securely on file. This card may be used to pay for any patient responsibility amounts not covered by my health insurance, including co-payments, co-insurance, deductibles, and non-covered services.

I understand that:

- My insurance company will be billed for services rendered.
- Once my claim is processed, my insurance provider will inform DOCS of any balance due.
- I will receive an email notification of the remaining balance and the amount to be charged to my credit card on file.
- My credit card will be charged 10 days after notification is sent.
- Individual payments will not exceed $300 per transaction and will be charged every 28 days until the balance is paid in full.
- If a charge to my card is declined for any reason, I agree to provide a new valid credit, debit, or HSA card within 10 business days. If a new payment method is not provided within this timeframe, I understand that a $25 declined card fee may be assessed.
- I understand that patients with Medicare, Medicare Advantage (replacement plans), Medicaid, and Tricare are exempt from this credit card on file policy.
- I understand that if I choose not to provide a card on file, a $100 deposit will be required at the time of service, in addition to any applicable co-pays. This deposit may be refunded after insurance has processed the claim, provided that no balance is due.

This is a legal document. By signing, you agree that you understand and accept the terms on this form. You have the right to revoke the authorizations on this form at any time by notifying DOCS in writing, except to the extent that DOCS has already acted in reliance upon them. These authorizations will remain valid until I revoke them in writing.

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Patient Name

_____ _____

Patient Signature *Date*