Patient Name: **(PLEASE PRINT)**____ Date of Birth:___________

Dermatology Associates abides by the following HIPAA guidelines set by the government:

HIPAA – PATIENT CONSENT
The patient understands that:

- Reminders of upcoming scheduled appointment may be left on answering machine or with a family member, and/or a post card may be sent to your household.
- Protected health information may be disclosed or used for treatment, payment or health care options.
- The Practice has a "Notice of Privacy Practices" and the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this Consent in writing at any time.
- Notification regarding the availability of pathology or laboratory results may be left on your answering machine or with a family member (**results will not** be left to any one other than the patient or a family member listed below).

This consent was signed by: X___________________________________ **Date:** _____________
(Signature of Patient or Legal Representative)

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS
I am authorizing disclosure of any of my medical records to the following people:

1. ____________________________ ___________________________________
(Name) (Relationship)
2. ____________________________ ___________________________________
(Name) (Relationship)

****

The following are internal policies set in place by the administration of Dermatology Associates of Wisconsin. Your signature is required at the bottom of the form in order to be seen by any of our providers.

Insurance filing
As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will make two attempts to settle any outstanding bill with your insurance company. Claims not paid by your insurance carrier within 90 days will become your responsibility. Dermatology Associates of Wisconsin will furnish information required by the insurance company to receive payment. Benefits should be paid directly to Dermatology Associates from your insurance company, if your insurance company pays the patient directly, payment will be expected within 10 days.

Collection fee or Non sufficient funds
Additional charges will apply if sent to collection or if a notice is received from the bank for non sufficient funds.
A 12% charge will be applied if sent to collection. A $35.00 charge will be applied for non-sufficient funds.

Medicare Disclosure
I request that payment of authorized Medicare benefits be made on my behalf to Dermatology Associates of Wisconsin, S.C. for any services furnished to me by that provider. I authorize Dermatology Associates of Wisconsin to release medical information to the Health Care Financing Administration or its agent in order to determine the benefits payable for related services.

Uninsured Patients

Each visit a $75.00 payment toward services rendered is due on the date of service prior to your examination. For patients undergoing surgery, a $300.00 payment toward services rendered is due on the date of service prior to your surgery. A statement with the balance due for services provided will be mailed to you within a few days. If the balance is paid in full within two weeks from the date of the statement, a 20% discount for cash or a 15% discount for credit card will apply. Cosmetic procedure, lab fees, pathology fees and injectables are not eligible for discount. **Patient or responsible party initials:** ________

Co-payments or Co-insurance
Payment is due on the date of service prior to seeing the provider.

Cosmetic procedures
Payment is due in full prior to treatment.

****

X____ DATE: ___/_____/____ until revoked
Signature of Patient or Legal Representative