SKIN PROFESSIONALS WEST

General Consent Form

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include lab tests, procedures such as biopsies and destructions, other diagnostic tests. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatment, tests and procedures and that I have the right to refuse his/her recommendations.

BILLING AUTHORIZATION: I hereby authorize SKIN PROFESSIONALS WEST to release requested medical information to my insurance company to collect payment for any charges.

ASSIGNMENT OF BENEFITS: I hereby request that payment of insurance benefits be made directly to SKIN PROFESSIONALS WEST on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to services for myself or my dependent. It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay any balances promptly.

MEDICARE AUTHORIZATION: I request the payment of authorized Medicare benefits be made on my behalf to SKIN PROFESSIONALS WEST for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration 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. I understand that Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those services rendered.

FINANCIAL POLICY: I hereby acknowledge that I had access to a copy of the financial policy of SKIN PROFESSIONALS WEST and have been able to review the policy. I know that any co-pay is due at the time of service. I am familiar with SKIN PROFESSIONALS WEST policies on insurance benefits, claims, referrals, precertification, and lack of insurance. I am also aware of SKIN PROFESSIONALS WEST policies on finance charges and past due balances as well.

PATIENT'S RIGHT TO PRIVACY: I acknowledge I have been made aware of Skin Professionals West HIPAA Privacy Practices that pertain to my rights regarding the use and disclosure of my protected health information. These rights are more fully described in this office's Notice of Privacy Practices. I understand a copy of Skin Professionals West Privacy Practices is available to me on the practice website or in the office upon my request. I consent to be contacted by Skin Prfessionals West or other business associates at the physical address, phone numbers and emails provided.

BLOOD TESTING: I understand that while receiving care, a healthcare worker may accidently be exposed to my blood or other bodily fluid. If this rare event occurs, I consent to my blood be tested for the presence of infectious diseases to protect the health care worker.

ELECTRONIC PRESCRIBING: I authorize SKIN PROFESSIONALS WEST to retrieve my medication history from my pharmacy through their e-prescribing system and then import my current medications into my electronic medical record.

PHOTOGRAPHY: I consent to mt pictures being taken for medical records, communication with other health care providers involved in my care, publications and marketing materials without revealing my identity.

AUTHORIZATION TO LEAVE DETAILED PHONE MESSAGES: I authorize staff of Skin Professionals West to call or leave **detailed messages** with information about my health, billing, financials and prescriptions at the following phone numbers:

Home: Cell: Work:

AUTHORIZATION TO COMMUNICATE: I authorize Skin Professionals West to communicate with me via □ phone □ text □ email

Home: Cell: Email:

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I authorize Skin Professionals West to discuss **ALL ASPECTS** of my protected health information including but not limited to tests results, billing, financials and prescription information with the following individuals:

Name: Relationship: Phone:

Name: Relationship: Phone:

PRINT Name of patient: **Date of Birth**:

PRINT Name of guardian or legal representative signing for patient:

Signature: **Date:**