# Central Carolina Skin & Dermatology Center
# Patient Consent Form & HIPPA Acknowledgement

This health care facility will use your health information for the following reasons:

**Treatment:** We will use your health care information to make decisions about the provisions, coordination or management of your health care, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may be necessary to share your health information with another physician whom we need to consult with respect to your care. By signing below, you understand that treatment for your condition(s) will be based upon the information provided. You accept full responsibility if you have provided inaccurate, incomplete or misleading information. You also certify that the identifying information, addresses and telephone numbers, is correct and agree to inform this office if such information changes or becomes outdated.

**Payment:** We may need to use or disclose information in our health care records in order to obtain reimbursement from you or your health insurance carrier, or from another insurer for the services rendered to you. This may include determination of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related health care data processing through our system.

**Co-payment:** All co-payment amounts are due and payable at the time of check-in. This policy is in accordance with the legal requirements for collecting patient responsibility amounts.

**Insurance Filing:** We will not file insurance for you if we do not have a copy of your insurance card. Payment in full will be required at the time of service. You are responsible for notifying us of any changes in your insurance and providing copies of new cards at time of service.

**Minor Children:** The responsibility for payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of this office.

**Canceled Appointments:** We understand that you may need to change or reschedule your appointment. In order to serve all of our patients in a timely fashion, you must cancel your appointment at least 24 hours in advance. If you do not provide a 24-hour notice, you will be charged a $50 fee.

**Missed or No-Show Appointments:** Our policy is to charge for missed or no-show appointments at the rate of $50. Please help us serve you better by keeping scheduled appointments or notifying us 24 hours in advance. If you do not provide a 24-hour notice, you will be charged a $50 fee.

**HIPPA Acknowledgement:** Posted in our lobby is the Notice of Privacy Practices, describing how medical information about you may be used and disclosed and how you can have access to this information. If you wish to have a copy of this notice for your personal records, please ask our receptionist. Otherwise, you acknowledge receipt of the Notice of Privacy Practices.

**Product Returns:** Any products must be returned within 14 days in order to receive a refund. Products must be returned unused and in the state they were received. Products that are used will only be given a refund if there is an adverse effect and this must be reported, documented and signed by the patient.

**Authorization:** I agree to be responsible for my medical expenses regardless of insurance coverage; therefore, I authorize my insurance company, attorney, or other parties to pay directly to Central Carolina Skin & Dermatology Center and/or provide any information regarding payment of my bill. If my account should become delinquent, I agree to pay all costs incurred in collecting the account. I have read, understood, and agreed to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

Patient Signature: _____ Date: ___ /___ /___