GEORGE DERMATOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, George Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO) (available upon request). Please refer to the George Dermatology Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. George Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at 8888 Ladue Rd., Suite 120, St. Louis, MO 63124.

With my consent, George Dermatology may email, fax, mail, or verbally send to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment card reminders, financial, or medication information. I have the right to request that George Dermatology restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

I authorize the release of medical information necessary to process my claim and also authorize payment of medical benefits to George Dermatology. I understand that I am responsible for any and all balances remaining after insurance pays. I will be responsible for all balances if I do not have insurance.

By signing this form, I am consenting to George Dermatology's use and disclosure of my PHI or carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, George Dermatology may decline to provide treatment to me. With my consent, Dr. George and/or staff may call my home or other designated locations and leave a message on voicemail.

If I am unavailable, I give Dr. George and/or staff consent to discuss my medical or financial status with:

1._____

(Include names, relationship, and phone number)

2._____

(Include names, relationship, and phone number)

_____

Please PRINT Patient's Name

_____ _____

Signature of Patient or Legal Guardian Today's Date

_____

Patient's Email Address

GEORGE DERMATOLOGY FINANCIAL POLICY

Thank you for choosing George Dermatology. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. Please read the following carefully and sign at the bottom to confirm your understanding.

1. Insurance: It is the responsibility of the patient to provide accurate insurance and personal information. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our office by another physician does not guarantee that your insurance will cover our services.

2. **Co-Pays and Outstanding Balances:** It is the policy of George Dermatology that payment is due at the time of service. Co-Pays must be paid in full. All balances on your account must be paid prior to, or at the time of your visit. This includes, but is not limited to co-insurance and deductibles. If you cannot pay your balance at the time of visit, you will need to reschedule your appointment. Our office does not offer payment plans at this time.

3. **Self-Pay and Cosmetic Appointments:** Payment is expected in full at the time of service.

4. **Cancellations and Missed Appointments**:

Office Visits: I understand that it is my responsibility to cancel my appointment at least 24 hours before the scheduled date and time; otherwise a $50.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.

Surgical Appointments/PRP: I understand that it is my responsibility to cancel my appointment at least 24 hours before the scheduled date and time; otherwise a $200.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
We understand that unexpected life events and illnesses do occur. If this happens, please call our office as soon as possible to cancel or rescheduled your appointment.

5. **Referrals:** If your insurance requires a referral, it is your responsibility to provide the referral ***prior to your visit.***

6. **Pathology:** On occasion, pathology is ordered by physicians to properly diagnose certain skin disorders. To provide quality care for our patients, we utilize an independent licensed lab with analysis performed by a Board-Certified Dermatopathologist who specializes in the microscopic diagnoses of skin disorders. **Charges for these services are in addition to your office visit and procedure charge.**

7. **Requests for Medical Records / Forms (FMLA):** There is a $25.00 fee for medical records, plus the cost of mailing and/or electronic device. FMLA, medical, and other such policy forms that need to be filled out by our office will require a $10.00 fee. These fees must be paid before the records/forms will be sent.

8. **Accepted Payment Methods:** George Dermatology accepts cash, Visa, Mastercard, Discover, and personal checks with proper identification (valid Driver's License or photo ID), checks can be made payable to "George Dermatology". There will be a $30.00 charge for any returned checks.

I have read the above financial policies and understand my financial responsibilities as a patient at George Dermatology. I understand that failure to make a payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees. If I do not sign this consent, George Dermatology may decline to provide treatment to me.

_____
Please PRINT patient's name

_____ _____
PATIENT/GUARDIAN SIGNATURE Date

GEORGE DERMATOLOGY
CREDIT CARD ON FILE POLICY

☐ If you have Medicare and a Supplemental Insurance please check this box, along with printing and signing your name at the bottom of the page.

Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. Many policies have large deductibles and/or copayments that won't be known until after your services are submitted to your insurance carrier. Even if a procedure is covered by insurance, you may still receive a bill. These external factors make it necessary for George Dermatology to maintain a credit card on file for all patients. The card information is stored in a confidential, secure merchant account.

Once your insurance company notifies us how much of the bill is your responsibility, we will mail you one statement to obtain payment. After 30 days, we will charge your credit/debit/HSA card and provide you with a confirmation of the charge. If the balance is over $200, you will receive one courtesy call from our billing office regarding the payment a few days prior to charging the card.

By signing this form, you authorize George Dermatology to charge your card on file for services for which you are responsible.

Credit Card on File

Name as it appears on credit card: _____ Card expiration date: _____

Cardholder's Signature: _____ Last 4 digits of card: _____

Relationship to patient: _____

_____
Please PRINT patient's name

_____ _____
PATIENT/GUARDIAN SIGNATURE Date