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Email and Text Message Consent

We wish to communicate with you via email and text message.

You understand that the use of these forms of communication have a number of risks. These risks include, but are not limited to, the following: (i) emails and text messages we send or receive are generally not encrypted and may not be secure; (ii) emails and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients; (iii) third parties may access and read any emails and text messages we send; and (iv) emails and text messages may contain sensitive and confidential health information.

We will use reasonable means to protect the security and confidentiality of e-mail and text message information sent and received; however, because of the risks outlined above, we cannot guarantee the security and confidentiality of email and text message communication and will not be liable for the improper disclosure of confidential information that is not caused by our intentional misconduct. Therefore, our patients must specifically grant his or her consent to the use of email and text messages for communication between the patient and the practice.

You understand that you are not required to consent to receiving communication via email and text message. In the event you do consent, you also understand that you may revoke this consent at any time by advising us in writing. Your refusal or revocation of consent will not affect your ability to obtain future health care with our practice, nor will it cause the loss of any benefits to which you are otherwise entitled.

You acknowledge that you have read and fully understand this consent form. You understand the risks associated with the use of email and text messaging as a form of communication, and hereby give us permission to communicate with you regarding appointments, scheduling, billing, payments, test results and your medical records through the use of email and text messages.

HIPAA Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of the practice's Notice of Privacy Practices and have also been given an opportunity to ask questions. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse PHI.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a plastic surgeon.
- Payment means such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health care operations include the business aspects of running our practice, such as conducting quality assessments and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders. We also may use and disclose health information to tell you about treatment alternatives or other health-related benefits and services.

When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

We may use or disclose your PHI as more fully permitted or required under HIPAA, or to the extent that the law requires such use or disclosure for the following purposes:

- to a public health authority for public health activities and purposes;
- to a person/company subject to the jurisdiction of the U.S. Food and Drug Administration (FDA);
- to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition;

- to a public health authority that is authorized by law to receive reports of abuse or neglect;
- to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections;
- in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal;
- for law enforcement purposes;
- to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law;
- if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
- in the event you are Armed Forces personnel, we may use or disclose your PHI to authorized federal officials for conducting national security and intelligence activities;
- to comply with workers' compensation laws and other similar legally established programs and/or as may be required by your workers compensation insurance coverage;
- if you are an inmate of a correctional institution or under the custody of a law enforcement official to such institutions;
- for research purposes;
- to provide legally required notices of unauthorized access to or disclosure of your PHI that may include appropriate governmental agencies;
- to the Secretary of the Department of Health and Human Services to investigate or determine the office's compliance with the requirements of applicable law and regulations;
- for proof of immunization to a school about a student or prospective student of such school, as required by State or other law; and
- if you need emergency treatment or if we are required by law to treat you.

While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your PHI.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- most uses and disclosures of psychotherapy notes;
- uses and disclosures of your PHI for marketing purposes, including subsidized treatment and health care operations;
- disclosures that constitute a sale of PHI under HIPAA; and
- other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including treatment, payment or healthcare operations or those related to disclosures of family members, other relatives, close personal

friends, or any other person identified by you. We are, however, not required to honor a request for restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI charged at a reasonable cost-based fee for copies.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket," in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI, to provide you the notice of our legal duties and our privacy practice with respect to PHI and to notify affected individuals following a breach of unsecured protected health information.

This notice is effective as of March 30, 2020 and it is our intention to abide by the terms of this Notice of Privacy Practices and HIPAA regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. All complaints must be made in writing. We will not retaliate against you for filing a complaint.

Feel free to contact the practice office manager for more information, in person or in writing.

Patient Financial Responsibility Policy and Acknowledgement

Patients are required to pay for health care and/or cosmetic services at the time services are provided. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, credit and debit cards.

It is your responsibility to bring your most current insurance card with you to <u>every</u> office visit. You will be asked to present the card upon arrival. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. If this information is not provided, you will be expected to pay in full at the time of service.

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Insurance Policyholders: Co-payments must be paid in full at the time of service. If your insurance does not cover certain services (typically cosmetic services) or if you do not have an active, valid insurance card, payment is required at the time of service. Please check with your insurance plan to verify that we are a participating provider. If we are not a participating provider with your insurance company, you are required to pay in full for services at the time of your visit. Upon request, we will provide you with the information you will need to file a claim with your insurance company.

Referrals: Some insurance companies require a referral to see a specialist for any reason. It is your responsibility to call your insurance company to determine if a referral is needed. If a referral is required, you must have your primary care physician complete the referral prior to your visit.

Payment of account balance: Any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the three major credit bureaus if not paid in a timely manner.

Appointments not changed or cancelled in advance: If you need to cancel or change an appointment, please contact our office at least 24 hours before your scheduled appointment. If you miss your appointment and it was not cancelled or changed at least 24 hours in advance, a late fee of $50.00 will be charged. These charges are not covered by insurance.

Covered/Non-Covered Services: We are not responsible for knowing your insurance policy and what services are eligible for coverage. You must contact your insurance company to determine what your policy will cover.

Please understand that our billing staff will file all claims for covered services with your insurance company if the treating physician is a provider under your insurance. By signing this form, you are acknowledging that you understand you are responsible for any balances that may be due to the physician as a result of:

- co-insurance or co-payments
- annual deductible amounts
- non-covered services
- out-of-network charges
- terminated coverage
- exhausted benefits
- no insurance coverage
- failure to respond to insurance company correspondence or inquiries
- fees related to non-payment, missed appointments, returned checks & any other applicable fee

Release of Information and Payment Authorization:

All Insurance Companies and Third Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to the medical practice all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding the medical practice's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third parties. A list of usual and customary charges is available

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upon request. I consent to any request for review or appeal by the medical practice to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer. I authorize the release of any and all medical information to my insurance carrier and/or responsible third-party payers regarding services rendered.

Medicare and Medicaid: If I am covered by Medicare or Medicaid, I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize that any holder of medical or other information about me may release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers, any and all information needed for this or a related Medicare or Medicaid claim. I authorize and request that payment be made directly to the medical practice.

Independent Laboratory Billing: I understand that all specimens (for example, biopsies and cultures) will be sent to and billed by an independent laboratory. I understand that all outside laboratory testing will be billed from the specific laboratory directly to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment for any reason.

Guarantee of Payment: I understand that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered to me or the patient indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days. If the balance is not paid within 30 days, I understand my account will be subject to the collection process, including collection fees or attorney's fees and costs, and that I may be turned away for non-emergent services until the balance is paid. I hereby grant any such collection agency to contact me via telephone, text, and e-mail and further allow for the use of robocalls.

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Financial Policy (continued)

REFERRALS
If your insurance requires a referral, it is your responsibility to make sure that the referral is received *prior to your visit* and that all information is correct. Referrals with incorrect or outdated information will not be accepted and your appointment will need to be rescheduled.

MISSED APPOINTMENTS
We reserve the right to charge for missed appointments. If an appointment is not cancelled or rescheduled with at least 24 hours' notice based on a business day, a ***$50 fee will be applied for medical dermatology appointments, and a $100 fee will be applied for surgery and cosmetic appointments (including Mohs surgery).*** These charges will be your responsibility and will be billed directly to you.

For established patients, if you have missed or cancelled a total of 3 appointments with less than 24 hours' notice based on a business day, within a year, you may be discharged from our practice under our missed appointment policy. For new patients, if you have missed or cancelled a total of 2 appointments with less than 24 hours' notice based on a business day, you will not be rescheduled.

FORMS COMPLETION (beginning January 1, 2022)
We reserve the right to charge a fee for the completion of a form or letter (disability, school, MVA, camps, etc.). Fees are as follows: simple/single page forms: $10 for each form; complex/multi-page forms: $25 for each form. ***Fees are due at the time of the request. We ask for a minimum of 48 business hours' notice to complete the form(s). For multiple forms or multi-page forms we may require additional time for completion.***

_____ _____ _____/_____/_____

Signature of Patient or Guardian Name of Patient or Guardian Date