Anne Arundel DERMATOLOGY

GENERAL AGREEMENT TO OUTPATIENT SERVICES

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients and then, at least annually or when the patient's insurance changes.

1) **CONSENT TO TREATMENT**: I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology (AAD") entities. I understand that such services may include may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2) **PAYMENT FOR SERVICES**: I understand that AAD may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Anne Arundel Dermatology. If I should receive the payments, I understand that I will be responsible for paying AAD. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. I understand that AAD will hold me responsible in any one of the following situations:

   a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
   b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
   c. When my health plan does not participate with AAD for the services I want or need and I agree to pay for my care myself.
   d. When I receive services that are not covered under my health plan including cosmetic services.

   If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have AAD act on my behalf to obtain my benefits when AAD asks to do so. I also agree that AAD can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

3) **CONSENT TO PHOTOGRAPH**: I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

4) **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to AAD for the purpose of continued treatment.

5) **MY PERSONAL BELONGINGS**: I understand that I am responsible for my personal belongings and valuables.

6) **RELEASE OF INFORMATION:** I authorize AAD practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from regarding prior encounter(s) at other AAD practice locations may be made available to subsequent AAD-affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

   If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

   Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access

my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES to FAMILY and FRIENDS: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Nam	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

7) **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT**: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for AAD and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of AAD. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

Home Phone: _____. Cell Phone:_____.
Authorized email address: _____.

OR

_____(Initials) I decline to receive communication via text
_____(Initials) I decline to receive communication via email.

Revocation

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name:_____

Patient/Patient Representative Signature:_____
Date: Time:

8) **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received/reviewed AAD's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____ Signature:_____

Relationship to Patient (Self/Parent/Personal Representative): _____