Anne Arundel
DERMATOLOGY
and Affiliate Practices

Patient Name: _____
Date of birth: _____

General Consent/Agreement to Outpatient Services

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients, at least once a year for established patients, and any time there are changes in patient name, address, phone or other insurance information.

CONSENT TO TREATMENT: I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology & Affiliate(s). I understand that such services 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.

PATHOLOGY/LAB CHARGES: Pathology and lab charges are billed separately. If your provider elected to send your tissue to the Anne Arundel affiliated Pathology Lab or a different pathology lab, you will receive a separate bill from the pathology provider for charges resulting from those services. There are two components to dermatopathology services - the technical component, or TC, which encompasses slide preparation and the professional component, or PC, which encompasses review of the prepared slides under a microscope and professional interpretation of the results. Your detailed bill will outline the components of the service and the specific provider of each service.

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.

ELECTRONIC PRESCRIBING: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to Anne Arundel Dermatology & Affiliates for the purpose of continued treatment.

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

DISCLOSURES to FAMILY and FRIENDS: Should I wish to 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, I can document this request in writing by completing the Authorization for Release Form, this form can be requested from an office team member. Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

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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 Anne Arundel Dermatology & Affiliate(s) 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 Anne Arundel & Affiliates. 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, to provide newsletters and marketing promotions, 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.

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing as previously stated above. This modification request can be completed through our Communication Revocation Form, this form can be requested from an office team member.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received/reviewed Anne Arundel Dermatology & Affiliate(s) Notice of Privacy Practices. I understand that I may contact the Privacy Officer at compliance@aadermatology.com, if I have a question or complaint. I also understand that I have a right to file a complaint with Secretary of the Department of Health and Human Services. 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. You have the right to get a copy of this notice electronically. Even if you have agreed to receive notice electronically, you also have the right to request a paper copy of this notice.

I AGREE TO THE ITEMS OUTLINED IN THIS AGREEMENT.

Name (Print): _____ Signature: _____ Date: _____

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

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Patient Name: _____
Patient Date of birth: _____

ANNE ARUNDEL DERMATOLOGY & AFFILIATE(S) FINANCIAL POLICY ACKNOWLEDGEMENT

I agree to furnish current, valid proof of insurance coverage as well as a copy of my driver's license or other state-issued photo ID at each office visit to confirm my identity and coverage. I will report any changes in insurance or other personal information promptly.
I agree that if I am a parent/ legally authorized representative/guarantor consenting to care and treatment of a minor child, I am responsible for payment and will receive billing statements. Parents are presumed to be legal representatives for their minor children unless legal documents proving otherwise are shared with the office. Please discuss any insurance or custody concerns with the office manager. I understand that knowing about my insurance coverage is my responsibility and will contact the insurer for coverage questions. If my carrier requests information from me, I agree to comply promptly with such requests. Anne Arundel Dermatology & Affiliate(s) is authorized to bill my health plan for the care I receive and I know that payments from my health plan will go directly to Anne Arundel Dermatology. If I should receive the payments, I understand that I will be responsible for paying Anne Arundel Dermatology.

CANCELLATION FEE

I understand that if I do not cancel my scheduled appointment with 24 hours advance notice, or I no-show a scheduled appointment, I am subject to a cancellation fee. If I cancel my appointment 24 hours in advance, I can reschedule without fee. Cancellation fees are posted in each clinic location and are communicated during scheduling, as well as during appointment confirmation.

OUT OF POCKET COSTS

Co-pays, co-insurance, deductibles and all non-covered charges are your financial responsibility and due at the time of your visit. Co-pays are collected at check-in. Any additional financial responsibility will be collected at check-out. Once your insurer processes your claim, you will be billed for any additional amounts due.

COSMETIC FINANCIAL AGREEMENT

I have full access to Anne Arundel Dermatology & Affiliate(s) Cosmetic Financial Agreement, terms & policies ONLINE. I hereby acknowledge that any cosmetic procedures are my financial responsibility at time of service.

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NEW PATIENT/WALK-IN PRODUCT PURCHASE POLICY

All new patient paperwork must be completed, and a patient chart entered in to our secure and HIPAA compliant electronic medical records system before a transaction or purchase can be made. This may also require associated consent forms signed and reviewed by a provider. No exceptions will be made.

RETURN POLICY

All skincare retail product (both RX and non-RX) sales are final and monies paid are non-refundable. In case of documented allergic reaction, or clearly defective product, exchanges can be made within 14 days of purchase for skin care product credit only. Must have original proof of purchase and exchange can only be made at original purchase location, per management approval.

PRODUCT PURCHASE ACKNOWLEDGEMENT

At Anne Arundel Dermatology & Affiliated Practices we sell and dispense products to allow convenience for our patients. As there are similar items which can be obtained locally, we never want patients to feel pressured to purchase products here. If you would like to purchase here, please feel free to ask for our assistance. If you prefer to purchase products elsewhere, realize that it will never interfere with the physician/patient relationship and a patient should never feel any obligation to make a purchase. I realize that I am in no way bound to purchase products from Anne Arundel Dermatology & Affiliated Practices, and do this of my own free choosing.

Name (Printed): _____

Signature: _____ Date: _____

Relationship to Patient (self/parent/representative): _____

Anne Arundel DERMATOLOGY *and Affiliates*

Patient Name: _____

Patient DOB: _____

Authorization for Release of Health Information

RELEASE OF INFORMATION: I authorize AADerm practice site(s) to release healthcare information for purposes of treatment, payment or health operations. Healthcare information from or regarding prior encounter(s) at other AADerm practice locations may be made available to subsequent AADerm-affiliate 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:

	Name	Relationship	Contact Number
1:			
2:			
3:			

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

I **agree** to **the items as outlined in the Agreement.**

Patient Signature (Self/Parent: for under 18/Personal Representative):_____ Date: _____

Printed Name (Self/Parent: for under 18/Personal Representative):_____ Date: _____