Informed Consent and Financial Policy Form

Consent for Treatment: By signing this form, I authorize Dermatology Associates of Katy's practitioners and staff to evaluate and treat me to include but not limited to: biopsies; excisions, shave excisions and removals; Electrodessication and Curettage (ED&C); liquid nitrogen cryosurgery; intralesional injections; intramuscular injections. All procedures will be fully explained to me prior to treatment and as with any treatment plan, I understand it is my responsibility to follow the recommended treatment plan and that there are potential risks involved. The most common risks are, but are not limited to: scarring (any procedure can produce a permanent scar); infection; bleeding; reaction to anesthesia; pain; nerve injury resulting in no sensation or movement in the surrounding area; blood vessel injury which could cause localized death of skin and tissue; allergic reactions; and/or potentially life threatening reactions to surgical procedures.

How we may use and disclose Protected Health Information (PHI): By signing this form, you understand we may use and disclose PHI that identifies you and the health condition(s) for which you are being treated. You may revoke such permission at any time by writing to the Privacy Officer at 23510 Kingsland Blvd Ste 110, Katy, TX 77494. Please refer to our Patient Privacy and Protected Health Information policy on our website for the complete policy. You have a right to a paper copy of this policy by requesting this from our Privacy Officer. Except for the purposes described below, we will use and disclose PHI only with your written permission:

- Treatment: We may use and disclose PHI for your treatment and to provide you with treatment related health care services. We may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

- Payment: We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

- Health Care Operations: We may use or disclose your PHI in order to support the business activities of your physician’s practice. The activities include, but are not limited to: quality assessment activities; employee review activities; licensing; and conducting or arranging for other business activities.

- Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose PHI such as your name, email address, physical address or phone number to contact you to remind you that you have an appointment with us. We may text out reminders of upcoming appointments. I understand that these reminders will be in a text message format which will allow anyone who sees that text message to know that I have a dermatology appointment with no further detail. We also may use and disclose PHI (name, email, address, phone number) to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

- Individuals Involved in Your Care or Payment for Your Care: 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 legal representative and/or guardian.

Financial Obligations: Payment is due in full at the time service is provided by CDI. We accept cash, personal checks, debit and credit cards. We do not accept Care Credit. We will bill all insurance carriers with the insurance information you provide. Co-payments are due at the time of service. Although we are contracted with most insurance carries, it is the patient's responsibility to ensure we are covered with the patient's insurance plan. Once your claim has been processed, any outstanding balance will be your responsibility. For self-pay patients without insurance, non-participating insurances and out-of-network insurances, payment will be due in full at the time of service or pre-approved payment arrangements with our billing department.

Additional information in regards to your financial obligations:

- Referrals: Proper insurance documentation and any required referrals or required pre-authorizations is the responsibility of the patient. In the absence of appropriate referrals or preauthorization, you agree to accept full responsibility for any charges related to the services performed by Dermatology Associates of Katy. Additionally, if services are rendered which are outside the scope of your referral or authorization, you accept full responsibility for these charges.

- Laboratory Fees: You may be referred to an outside laboratory for tests. These fees will be billed to your insurance or to you by the laboratory. It is the patient's responsibility to use a laboratory contracted by your insurance provider. If a tissue sample needs to be read by a dermatopathologist, you may be charged and be responsible for those additional services.

- Authorization for Release of Medical Records: I authorize the release of medical records and information necessary to process insurance claims for medical and surgical benefits.

- Minor Patients: The accompanying parent/legal guardian of the minor child will be responsible for payment at the time of service, and for the minor's account balance.

- Delinquent Accounts and Collections: If a patient has not made payments on their account for 90 days, that account is considered delinquent and the patient will not be scheduled for any future appointments until the account is current. Delinquent accounts may be turned over to a collections agency, and you understand that you will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees.

- Return Check Fee: We will charge a $35.00 fee for returned checks.

Electronic Correspondence and Voicemails

I consent to receive emails, text messages or other communications, including automated or prerecorded messages from Dermatology Associates of Katy PLLC pertaining to my care and my health (such as automated reminders). By replying to emails, I acknowledge that I am aware that email is not a secure method of communication, and that I agree to the risks. I also authorize Dermatology Associates of Katy PLLC to leave voicemail messages on the telephone number(s) that I provide to Dermatology

Associates of Katy PLLC. I understand that I call the office and ask to not be contacted via phone or email.

Treatment of a Minor

The patient is under the age of 18 years, and I give permission for him/her to be evaluated/treated in my absence as the guardian.

Cancellation/No-Show Policy

We understand that situations arise necessitating moving an appointment time and/or date. If you need to cancel your scheduled appointment we require 24 hour notification (one business day) for non-surgical appointments, and 48 hour (two business days) for surgical appointments. Patients may be charged $35.00 for a missed non-surgical office visit | $75.00 for a missed procedure visit (surgery) | $100.00 for missed cosmetic visit. If a missed appointment fee is applied, future appointments will not be scheduled until the missed appointment fee is paid in full. If you miss two appointments within a 12 month period and/or do not comply with the appropriate cancelation notification procedures as listed above, we may not continue to see you as a patient.

With your signature, you verify that you have read, understand, and agree to comply with the above consents and policies. You acknowledge that you are at least 18 years of age, an emancipated minor, or the parent/legal guardian of a minor under 18 years of age. The permissions granted herein shall begin on the date of signature and shall remain effective until you terminate this Consent for Treatment. If you do not sign agreeing to these consents and policies, Dermatology Associates of Katy may decline providing you medical treatment.

Date: _____

Patient Name: _____

Parent/ Legal Guardian Name (If under 18 years of age): _____

Signature: _____