Southlake Dermatology
431 E. State Hwy 114, Suite 300
Southlake, TX 76092
Main 817.251.6500 Fax 817.442.0550

PRACTICE POLICIES:

1. We request a 24 hour cancellation notice. Failure to call, "no shows," will be charged a $50 administrative fee for an office visit, $75 for a surgery and $100 for a cosmetic appointment the fee is not billable to insurance. These policies include appointments with all providers and estheticians.
2. We attempt to make courtesy appointment reminders but are unable to provide this service at all times. If you do not receive a reminder and miss your appointment, this does not cancel our "no show" policy above.
3. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy to request refills.
4. Patients are responsible for verifying that our providers are under their insurance coverage.
5. All returned checks will be charged a $50 administrative fee.
6. If past bills are sent to collections, there will be a surcharge to cover the cost of the collection agency.

GENERAL PATIENT AUTHORIZATION

I hereby authorize providers of Southlake Dermatology to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice. In consideration of services rendered or to be rendered, I assign and transfer to Southlake Dermatology any benefits payable to me or on my behalf under any insurance coverage. I agree to fulfill all policy provisions which my insurance companies may require for payment. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I further agree to pay for any items or services not covered by the Medicare Program. I hereby understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract. If my insurance company does not pay for services rendered to me within 90 days, I understand and agree to pay any outstanding balance. I understand that I am responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Southlake Dermatology. I further understand should this account become delinquent; I shall pay the reasonable attorney or collections expenses. I understand that if I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or where there is prepayment for additional services.

I authorize Southlake Dermatology to release medical information pertaining to my diagnosis and/or treatment, laboratory test results, medical history, treatment, or any other such related information to:
Medicare or Medicaid, my insurance company or its designated representatives, any person(s) or entities financially responsible for my care or treatment, representatives of local, state, or federal agencies in accordance with law, employees or representatives of Southlake Dermatology for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Southlake Dermatology or the employees of Southlake Dermatology.

_____ _____
Signature of patient/Legally authorized representative Date

_____ _____
Print Name If a legal representative: relationship to patient

I authorize Southlake Dermatology to disclose my medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, or any related information to these listed below (physician, family member). The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed below will require specific authorization prior to the disclosure of my medical information.

_____ _____ _____ _____
Name Relationship Name Relationship

_____ _____ _____ _____
Name Relationship Name Relationship

I hereby give permission to Southlake Dermatology to notify me via the following:
☐Yes ☐No Appointment reminder, either by personal message or recorded message.
☐Yes ☐No A message to call the office for test results. Actual test results will not be left by message.

_____ _____
Signature of patient/Legally authorized representative Date

_____ _____
Print Name If a legal representative: relationship to patient

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PATIENT HIPAA AUTHORIZATION

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our notice may change.

The patient understands that:

·Protected health information may be disclosed or used for treatment, payment, or health care operations.
·The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
·The Practice reserves the right to change the Notice of Privacy Practices.
·The Practice may condition receipt of treatment upon the execution of this Authorization.
·The patient may revoke this authorization in writing at any time and all future disclosures will then cease.

I acknowledge that I have read the above authorization and have had access to read Southlake Dermatology's NOPP.

_____ _____
Signature of patient/Legally authorized representative Date

_____
Print Name If a legal representative: relationship to patient

Physician Assistant & Esthetician Information

This facility has on staff physician assistants and estheticians to assist in the delivery of medical dermatology care. A physician assistant "PA" is not a doctor but is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. I have read the above, and hereby consent to the services of a physician assistant for my healthcare needs. I understand that at any time I can request to see the physician.

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. The turnaround time for routine communications is 24 hours. The service provider may delay message delivery which is out of our control. Do not email us for urgent matters that require immediate attention. Communications related to diagnosis and treatment will be filed in your medical record. This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of the email, third parties may have access to messages. I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors. I understand and agree to the above policy. By signing below, you are agreeing that we may send medical related correspondence and newsletters to you via email, and that we may respond to your emails to us via email.

I acknowledge that I have read the above and give my consent for email communications and use of physician assistants and estheticians in the management of my care.

_____ _____
Signature of patient/Legally authorized representative Date

_____
Print Name If a legal representative: relationship to patient

MINOR PATIENTS (if applicable)

I give my permission for Southlake Dermatology to examine and treat _____, my minor child, in your office without me being present. Child's DOB: _____

_____ _____ _____
Parent or guardian name Parent or guardian signature Date

MEDICARE supplement: MEDIGAP RELEASE

For Medicare patients with supplemental Medigap insurance, a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize to release any information to my Medigap carrier needed to determine benefits.

_____ _____
Signed (insured person) Date