ORCHID
DERMATOLOGY

Financial Policy, Notice of Privacy Practices, Authorization and Payment Terms

We ask that you read and sign the following form to acknowledge your financial responsibility for the medical services provided here as well as our policy on the protection of your private health information. We will be happy to provide further clarification if necessary. To avoid any misunderstanding regarding our payment policies, please review our Financial Policy below. Payment is required for all services at the time they are rendered unless you are in a prepaidplan in which we participate. For those patients, applicable co-payments & deductibles will be collected at the time of service.

We accept payment via cash, check, debit cards, Master Card, Visa, Discover or American Express.

We may request a payment authorization form to be filled out at the time of check-in for patients who are minor, uninsured or with an outstanding balance, as well as patients with a non-participating insurance (including non-QMB Medicaid patients). Any outstanding balance from your visit will be mailed to your primary address. If there is any discrepancy or if you are unable to pay the balance in full, we ask that you contact our office immediately. Failure to settle your balance will result in further collection efforts and a collection fee may be assessed to your account. Please note that you may be billed separately for laboratory analysis if we are required to send specimens to an external laboratory. Ask us if any specimen was submitted to an external laboratory at time of checkout.

Participating Insurance: We are a provider for a variety of commercial insurance carriers, and we bill them as a courtesy to you. Prior to your visit, you will be informed whether or not we are a provider for your insurance plan. We accept payment for *covered* services from these insurance plans in accordance with our contracts. It is your responsibility to know and understand the guidelines of your insurance plan. You should attempt to seek medical care with physicians participating in your plan when possible. Insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy or talk with your insurance representative. You are responsible for co-insurance, deductible amounts, and payment for services not covered by your insurance at the time of service.

I authorize the release of medical information to my primary care or referring Physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the Orchid Dermatology Physician/Provider if applicable.

HMO Patients: While we make every effort to assist our patients with obtaining a referral/authorization from their primary care physician, it is ultimately the patient's responsibility to ensure the referral/authorization is in place for payment from their HMO. If no authorization is obtained for the patient appointment, it is the patient's responsibility to pay for that appointment in full.

Medicare Patients: We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any coinsurance, or charges not covered by Medicare. We do not bill supplemental insurance carriers. If your secondary insurance does not crossover with Medicare, you are responsible for that portion of your charges at the time of service (normally 20% of the covered charges).

Medicaid Patients: We are not a Medicaid provider. If you are not a Qualified Medicare Beneficiary, you are responsible for payment of all charges non-covered by Medicare at the time of service.

Uninsured & Non-participating insurance: If we are not a provider for your insurance you are responsible for payment of all charges at the time of service. For non-participating insurance, we will provide you with a receipt for reimbursement.

Refund Policy: We do not offer refunds for medical and cosmetic procedures. Product returns are limited to company policy. Over payment for services will be applied to the next available visit within one (1) year. If no follow-up visit is made, over payment funds will be reimbursed to the patient at the beginning of each calendar year per business policy.

Cosmetic Patient Policy: All cosmetic patients are required to keep a credit card on file $100 for toxin, microneedling, laser/coolpeel or $200 for filler, plasma pen, pdo threads to schedule and hold a time slot. If the patient is a no show or cancels after 24 hours the credit card on file will be charged. Cosmetic appointments are separate from general medical appointments, as such, funds are calculated and accounted for separately.

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No Show/Cancellation/Account Balance Policy: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a **fifty-dollar ($50) fee;** this will not be covered by your insurance company. Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a **one hundred-dollar ($100) fee;** this will not be covered by your insurance company. We will require that patients with self-pay balances pay their account balances to zero (O) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances must make payment arrangements prior to future appointments being made.

Tardy Policy: Patients that arrive more than 10 minutes after their scheduled appointment will need to be reschedule for a later date in order to be respectful of all patients and providers time.

I voluntarily consent to care treatment by Orchid Dermatology including diagnostic procedures, labs and medical treatment ordered by the attending physician/ARNP/PA-C. I understand that I have financial responsibility for payment of medical servicesprovided and hereby assume payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office. Additionally, in the event of non-payment, the undersigned guarantees payment of all costs of collections, including reasonable late fees and attorney's fees.

I have read and understand this financial policy and notice of privacy practices and agree to accept responsibility as described.

Printed Name:_____

Signature:_____ **Date:**_____/_____/_____

If Patient is UNABLE to consent, complete the following:

Patient is unable to consent because:_____and I hereby consent on his/her behalf and in his/her stead.

Printed Name:_____

Signature:_____ **Date:**_____/_____/_____

Orchid Dermatology is a division of Premier Dermatology LLC. Your financial statements and billing-related correspondence willcome from Premier Dermatology LLC. If at any time you have questions regarding your bill for services performed at Orchid Dermatology or by our pathology laboratory, please contact our Central Billing Office at (941) 312-5027 for assistance.

Yearly Medical Questionnaire

1. **Have you had the Pneumonia vaccine? YES_____ NO_____**
2. **Have you had the Flu shot this year? YES_____ NO _____**
3. **Have you had any changes to your medications this year? If so, please inform nurse in room.**
4. **Do you have a living will? YES_____ NO_____**
   - **If the answer is yes, please circle which one DNI (Do Not Intubate) or DNR (DO Not Resuscitate)**
5. **Do you have a medical Proxy(someone who can make medical decisions for you in the case you cannot?) YES_____ NO_____**
   - **If Yes, please list below.**
     Name:_____
     Phone Number:_____

Social Needs Screening

1. **Do you feel safe at home? YES_____ NO_____**
2. **Do you have any concerns about having enough food? YES_____ NO_____**
3. **Are you worried about losing your house? YES_____ NO_____**
4. **Do have adequate transportation? YES_____ NO_____**
5. **Do you have any concerns about paying your utilities? YES_____ NO_____**

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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 your Notice of Privacy Practices. 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 as stated here:

Notice of Privacy Practices: We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements. We may use and disclose medical information about you for one or more of the following reasons; medical treatment, payment, internal operations, appointment reminders, others involved in your care, as required by law, to avert a serious threat to health or safety, organ and tissue donation, public health risks, worker's compensation, government activities, lawsuits and disputes, law enforcement, coroner or medical examinations. A complete copy of our Notice of Privacy Practices is available for you at your request.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. I also authorize payment of medical benefits to the physician. Your signature below authorizes the release of your medical information and payment as listed above and signifies your willingness to comply with our financial policy.

By law, we are only permitted to discuss your diagnosis and treatment with you (the patient). In the event that a spouse, family member, or close friend may need this information, please list their name in the space provided below.
We cannot disclose any of your private health information to anyone who is not listed on this form. You have the right to inspect and copy the medical information that we maintain. To inspect a copy of your medical record, you must submit your request in writing. In some cases, there may be a fee associated with your request.

MAY WE CALL YOUR HOME AND LEAVE A DETAILED MESSAGE ON YOUR VOICEMAIL? YES_____ NO_____
MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? YES_____ NO_____
DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? YES_____ NO_____

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name:_____ Phone:_____ Relation:_____
Name:_____ Phone:_____ Relation:_____
Name:_____ Phone:_____ Relation:_____

OUR OFFICE WILL ADD BIOPSY RESULTS TO THE PATIENT PORTAL.

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the Orchid Dermatology Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

Printed Name:_____

Signature:_____ Date:_____/_____/_____

Parent, Spouse or Responsible Party: o **check here if same as patient**

Patient Name:_____

Date of Birth:_____/_____/_____ Social Sec.#_____-_____-_____ Gender: Male Female

Mailing Address: Street:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Email Address:_____