Bluegrass Dermatology Office Policies & HIPAA
(Health Insurance Portability and Accountability Act) Consent Form

The following is a review of our office policies and Insurance Portability and Accountability Act (HIPAA). Please review and sign below. Some policies may not pertain to your treatment today, but may for future treatments / procedures.

- **Payment responsibility:** The patient is ultimately responsible for all insurance deductibles, co-pays and coinsurance on the day of service (subject to plan limitation, and exclusions). We are not a Medicaid-provider and do not bill to Medicaid.
- **Payment options (For procedures not covered by insurance or balance dues):** Cash, check, Visa, Discover, American Express, Mastercard, Care Credit Visa, debit cards, money orders, and cashiers checks. Payment plans can be arranged with CareCredit Visa by GE Moneybank. All balances due that do not get paid within the first 30 days are subject the account being transferred to an outside collection agency. You can apply for CareCredit in our office today.
- **Insurance policies that require a referral from PCP**: Some insurance plans require a referral from the patient's primary care provider (or PCP). This referral needs to be initiated by the patient's PCP, by contacting the patient's insurance company. This is the only way the patient will receive benefits when seeing a specialist. **It is the patient's responsibility to make sure this has been done prior to each appointment date. Otherwise, the patient is responsible for ALL charges.**
- **Network Providers:** It is your responsibility to know if your provider is considered "In-network" by your insurance. Some insurance companies change their policy administrator and this can be difficult to identify from your insurance card. We encourage you to confirm your In-network status with our office each time you receive a new copy of your insurance card. **We are not a Medicaid provider and Medicaid does not offer out of network benefits; we do not bill to Medicaid and therefore patients will not receive reimbursement from their Medicaid plan.**
- **Prescription refill policy:** Our physicians prescribe their patients sufficient refills to last until their next follow-up appointment; therefore, we are unable to refill prescriptions by telephone. If you would like refills of any medications prescribed by one of our physicians, please ask the physician you are seeing today during your exam.
- **Laboratory facilities:** All surgical pathology and other lab specimens are submitted to outside laboratories for processing and analysis. The patient will receive a separate bill from the laboratory that processes and tests specimens. It is the patient's responsibility to let us know if your insurance company requires that we send your labs to a specific pathologist in order for you to receive full benefits.
- **Additional Fee:** There is a $25 fee assessed if you fail to cancel or reschedule an appointment at least 24 hours prior or you no-show the appointment.

As required by the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**, this practice may use your health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

- 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 physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments. We accept payment in the form of cash, check, Discover, American Express, Visa, Mastercard, debit cards, money orders, and cashiers checks. We also participate with Care Credit Financing.

- **Acknowledgement of Receipt of Privacy Practices:** I acknowledge the practice has a copy (as well as displayed in their lobby) of the Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information, and that I can obtain a copy per request.
- **Consent to Treat:** I hereby authorize examination and treatment by Bluegrass Dermatology. I authorize release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration/CMS or intermediaries) and I assign payments for medical services to the physician(s). I understand that it is my responsibility to remit payments for charges not covered by my insurance company. I understand that it is my responsibility to see that all claims, pre-certifications and authorizations are completed by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent. I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential by our HIPAA policy.

CONSENT: I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

- I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.
- I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.
- Is there anyone (i.e. spouse, parent, guardian or family member) you authorize us to share any medical information with, if you are not available? [ ] YES [ ] NO

    - If yes, please provide their name & contact information below:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

RESTRICTION REQUEST SECTION ***If you do NOT want the physicians or staff at Bluegrass Dermatology to leave test result; appointment; or billing/account information on your personal voicemail, please make note in the Restriction detail below.

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

_____

* If you are over 18 years of age and under your parent's insurance policy, please check the box: [ ]

Signature of Responsible Party: _____ Date: _____