



## **Consent to be Photographed**

I consent for medical photographs to be taken of me by the staff or representatives of Geria Dermatology. I understand that the images will be placed in my medical record and may be used for evaluation by employees of Geria Dermatology. I understand the photographs captured will not be used for social media or promotional purposes. I also give permission for transfer of these photographs via a encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (e.g. communication with my primary care physician).

If I wish to withdraw my consent in the future, I may do so with a written request.

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Responsible Party Name (if different from patient):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_



## **Credit Card on File Policy**

Geria Dermatology requires a credit card be kept on file. This card will only be charged in the event of a no-show or outstanding balance after 3 statements have been sent. We value your privacy and securely keep your payment information encrypted and stored in accordance with HIPAA guidelines. Once entered, we do not have access to your full card number information.

I hereby authorize Geria Dermatology to charge the credit card on file automatically for payments owed to my account for services rendered at their office. I agree to update any information regarding this account.

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Responsible Party Name (if different from patient):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_



## **HIPAA Authorization and Consent**

### HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§ 164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test

results, diagnosis, treatment and any plans for future care or treatment. <sup>[L]</sup><sub>[SEP]</sub> <sup>[L]</sup><sub>[SEP]</sub>

I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity.

I have the right to review this facility's notice prior to signing this authorization. <sup>[L]</sup><sub>[SEP]</sub> I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.



**HIPAA PRIVACY RULE OF PATIENT CONSENT AGREEMENT**

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§ 164.506(a)) I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x- rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Responsible Party Name (if different from patient):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_



**Insurance Signature on File**

I certify that the information given by me in applying for Insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my Insurance and/or Medicare benefits, and I authorize payment of these benefits to Dr. Aanand N. Geria on my behalf for any services and materials furnished.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of agency shown, and authorizes my doctor to act as my agent, as above.

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Responsible Party Name (if different from patient):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_



### **No Show Policy**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients who do not show up for their appointment without a call to cancel at least 24 hours before the appointment time will be considered as NO SHOW. Geria Dermatology, LLC has the right to charge a fee of \$50.00 for all missed appointments ("no shows"). \*Additional fees may be charged if the missed appointment was surgical or cosmetic in nature. \* "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid in full prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Responsible Party Name (if different from patient):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_



## **Office Financial Policy**

By signing this document, I am agreeing to the terms of this Financial Policy.

**PAYMENT AT TIME OF SERVICE:** Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate. You will be charged a \$25 service fee for any returned checks, no exceptions.

**INSURANCE:** Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time that you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services, and you will need to contact your insurance company for reimbursement. For those patients covered by insurance plans with which we ARE participating providers, all co-payments, deductibles and non-covered services are due at time of service. We will file the insurance claim to the insurance company. In the event that your insurance coverage changes to a plan with which we ARE NOT participating providers, we will require payment in full at the time of service and we will file your claim to the insurance company as a courtesy. Any charges that are not paid by your insurance company are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.



COLLECTIONS: Please note, if payment is not received from either you or your insurance company within 60 days from the date of service(s), your account will be considered delinquent and subject to referral to an outside collection agency

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Responsible Party Name (if different from patient):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_