Please acknowledge your consent by checking off the boxes: ☐ HIPAA ☐ FINANCIAL ☐ EMAIL*(optional)*

Signature: _____

Print: _____

This document contains information that requires your consent and acknowledgement. If you would like a copy of this consent to take with you, please request a copy from the front desk receptionist.

IMPORTANT: Please review this consent, and then complete the attached label by checking the appropriate boxes along with printing and signing your name.

HIPAA CONSENT: I hereby permit HealthySkin to use my health information, and/or to disclose my health information to any third party payor (health insurance company), or to any party involved in my health care. I understand that there is a Notice of Privacy Practices in the practice reception area available for me to read. This consent shall be in force and effect as long as I am a patient at this practice. I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician(s) at this practice. I understand the information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or states law to the extent the state law provides greater access rights).
- Refuse to sign this consent form.

EMAIL CONSENT: I understand that by providing my email address on my patient data sheet, I am subject to receiving email communication from Healthyskin, but am able to request to be removed from the mailing list at any time.

FINANCIAL CONSENT: All co-payments are the patient's responsibility. Patient agrees to pay for all medical services not paid by insurance coverage. If it becomes necessary to take enforcement to collect any amount due, whether in a court proceeding or otherwise, patient shall be responsible for all attorney's fees, court costs, and collections fees, as well as the value of time lost by the provider or employee's of provider, in any efforts to collect such debt.

Lab specimens will be sent to a reputable Pathology Lab. Such lab will bill their services separately. Patient is responsible for any costs not paid for by insurance. It is the patient's responsibility to verify insurance benefits, including deductible balances and limits, co-insurance, etc. Patient understands any procedures received will be charged in addition to an office visit, and such procedures may be applied to a deductible. **PROCEDURES INCLUDE, BUT ARE NOT LIMITED TO, BIOPSIES, ELECTRO-CAUTERY, INJECTIONS OR APPLICATION OF MEDICINE, SKIN TAG REMOVALS, CRYOSURGERY (liquid nitrogen).**

IMPORTANTLY, FINANCE CHARGES WILL BE ASSESSED ON ANY OUTSTANDING PATIENT BALANCES AT A RATE OF 1.5% PER MONTH. ADDITIONALLY, IF YOU FAIL TO CANCEL YOUR APPOINTMENT AT LEAST 24 HOURS IN ADVANCE AND/OR NO-SHOW YOUR APPOINTMENT, YOU MAY BE CHARGED A FEE OF $25.

By acknowledgement of this consent, I hereby authorize direct payment of surgical/medical benefits to SHEFTEL & ASSOCIATES DERMATOLOGY, LLP for services rendered by any providers of such group.

Rev. 8/2012