MIDWEST CENTER FOR DERMATOLOGY & COSMETIC SURGERY
A Part of DOCS DERMATOLOGISTS OF CENTRAL STATES

MRN:_____

CONSENT FOR TREATMENT

(Complete Every Three Years)

INITIALS_____

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

For the purpose of this consent, Dermatologists of Central States ("DOCS") includes all facilities providing healthcare services, physicians, other healthcare providers and staff of all subsidiaries and affiliates thereof.

Consent for Treatment

I consent to the provision of medical treatment which may include, but is not limited to, routine examination, diagnosis/diagnostic tests and general treatment to be performed by DOCS. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment. I understand that if further medical procedure(s) or surgery is required, I may need to sign specialized consents.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I authorize DOCS to use and disclose my protected health information in order to carry out treatment, payment or healthcare operations. I acknowledge that I have been presented with the Notice of Privacy Practices which provides a more complete description of how my protected heath information may be used or disclosed. I understand that I have the right to review the Notice prior to signing this consent. I understand that DOCS reserve the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office. An electronic version of our Notice of Privacy Practices may be found by visiting our website.

Financial Agreement

I authorize DOCS to bill my insurance carrier and that any payment of insurance benefits be made directly to DOCS. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO) or any other payer. I understand that it is my responsibility to verify with my insurance company if the provider is "in-network" to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.

I understand that self-pay accounts, co-payments, co-insurance, deductibles and non-covered services are required to be collected at the time of service.

I understand that services which are normally covered may be denied in a situation because of certain conditions (for example: non-allowable diagnosis) and I will be responsible for these balances.

I understand that cosmetic procedures are not covered/paid by healthcare plan(s) and I acknowledge that I am responsible for any balance due for such services.

I understand that an outside laboratory is used for pathology services. Billing for pathology services is separate and I am responsible for any balances related to pathology services.

I understand that DOCS may contact me by telephone (including mobile phone), and its affiliates and agents may use a pre-recorded/artificial voice messages and/or an automated telephone dialing system, or by text message or email for any communication related to my account(s).

I understand that DOCS may store my credit card on file for ease of future payments (DOCS's team members do not have access to credit card information – only last for digits). If you want to opt out, please let the front desk team know when checking in.

This is a legal document. By signing, you agree that you understand and accept the terms on this form. You have the right to revoke the authorizations on this form at any time by notifying DOCS in writing, except to the extent that DOCS has already acted in reliance upon them. These authorizations will remain valid until I revoke them in writing.

_____

Signature of Patient (or Authorized Representative) **Date**

_____

Printed Name of Patient (or Authorized Representative)

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If Authorized Representative, please explain authority to act on behalf of the Patient