FEBRUARY 2022 PATIENT FINANCIAL POLICY AGREEMENT

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologists

Thank you for choosing Westgate Skin & Cancer for your Dermatology needs. We aim to deliver outstanding and transparent service. It is important that patients understand their rights and responsibilities. Herein, "Westgate Skin & Cancer, PLLC" will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH POLICY

_______ **Scheduling Policy:** The Practice requires a Credit Card on File (CCOF) or an on-account deposit to hold appointments. The Practice securely stores and encrypts card information, and once stored, card information cannot be retrieved.

Select One (Required)

☐ **CCOF**: I understand, consent, and authorize Westgate Skin & Cancer to securely store my card on file and charge my card for any cancellation or rescheduling fees, telemed visits, or release of record requests.

☐ **Deposit**: I understand, consent, and authorize Westgate Skin & Cancer to keep a $50 deposit for consults or a $200 deposit for advanced procedures.

Select One (Optional)

Auto Bill: I do not want to receive a paper statement. You may automatically charge the card on file for any balance under:

☐ **$100** ☐ **$300** ☐ **$1,000** ☐ **All**

_______ **Statement of Financial Responsibility and Authorization to Treat:** I understand and consent that, except as defined by my health insurance, I am financially responsible for any and all charges for services rendered by the Practice. I understand that I have the right to call my insurance before care is received if I have questions. I understand that I have the right to refuse treatment for any reason including the inability to fulfill financial obligations. I authorize medical treatment and procedures to be performed on myself, or the patient listed below, at the discretion of the Practice's providers and staff.

_______ **In-Network Insurance Claims, Assignment, and Estimates:** I understand that the Practice will bill all provided in-network insurance policies for medically necessary services rendered. I understand and consent to the release of information to my insurance company regarding my treatment at the Practice. I authorize assignment of insurance payments to be made directly to the Practice for all insurance benefits. I understand that the Practice will verify my eligibility and benefits with my insurance company, but verification of benefits is not a guarantee of payment or coverage.

I consent to pay at the time of service for:

- Co-Pay estimates
- Deductible estimates
- Co-Insurance estimates
- Any other estimated out-of-pocket costs

I understand that I will be billed if:

- My insurance company pays less than what is estimated
- My insurance company denies my claim
- My insurance company does not pay within 90 days
- My insurance company recoups payment or benefits at a later date

_______ **Self-Pay Patients and or Out-of-Network Insurance Claims:** I understand that payment is due in full at the time of service. If I pay by cash, it is my responsibility to ensure that I receive a receipt for payment. I understand that elective services or packages must be purchased in full at the time of my visit and past services or procedures will not apply to the package. Packages expire 1 year from the date of purchase. I understand that I am responsible for filing out-of-network insurance claims and any insurance benefits are between myself (the patient) and my insurance company.

_______ **Practice Fees:** I understand and consent to pay the following fees that are not covered by my insurance. All appointments must be cancelled or rescheduled 24 business hours in advance.

- **No-Show Fee** – $50 for all medical consults, cosmetic consults, basic medical procedures, and basic cosmetic procedures
- **No-Show Procedure Fee** – $200 for all advanced procedures including fillers, surgeries, area laser treatments, and sclerotherapy
- **Returned Check Fee** – $50 in addition to any outstanding balance if my check is returned for any reason
- **Delinquent Account Fee** – I will pay my past due balance and an additional 34% service fee if my account is sent to collections
- **Re-Instatement Fee** – $200 if I am dismissed from the practice, and upon approval from the medical director, reinstate my care
- **Release-of-Records Service Fee** – $25 for the first 500 pages, $50 for over 500 pages for any request received with my signature

_______ **Pathology and Lab Fees:** I understand and consent to be billed by an outside lab for services rendered. I understand that certain procedures, such as biopsies or cultures, require pathology and or lab services. I will make financial arrangements directly with these organizations. Fees may range between $100 to $400 per sample/specimen and determination of fees may not be possible until after orders are processed.

_______ **Product Purchases:** I understand that the Practice has partnered with Dermly for all product purchases and product fulfillment. All product purchases are final, and should an issue arise with the product itself, the item can exchanged for similar/like products. Additional terms and conditions are available at dermly.com/terms

SIGNATURE

I understand that my signature below confirms that I have read, understand, and consent to Westgate Skin & Cancer's Financial Policies.

Patient, Guardian, or Responsible Individual Signature	Patient Name	Date Signed

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologist

Thank you for choosing Westgate Skin & Cancer for your Dermatology needs. We aim to deliver outstanding and transparent service. It is important that our patients understand their rights and responsibilities. Herein, Westgate Skin & Cancer, PLLC will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH SECTION

_______ **Receipt of Practice's Policies Acknowledgement:** I understand and acknowledge that I have been given the opportunity to read the Practice's policies. This includes the Notice of Privacy Practices, Financial Policies, and Office Policies. I have the right to request a copy of these documents in office or I can acquire them by visiting www.westgateskin.com.

- **Notice of Privacy Practices** – Your rights under HIPAA and how the Practice follows HIPAA law.
- **Financial Policies** – Your Financial Responsibilities and how the Practice addresses financial matters.
- **Office Policies** – General office policies and how the Practice handles care

_______ **Contact and Communications Consent:** I understand and acknowledge that I have been given the opportunity to confirm my communication rights under HIPAA. In the event the practice needs to communicate my information that is protected under HIPAA, I confirm that it is permissible to:

☐ Speak to a spouse or trusted person about my information. **Name**: ____

☐ Speak to an additional trusted person about my information. **Name**: ____

☐ Leave a message on a voicemail system that includes my information. **Number**: ______________________________

☐ **Dr. Epstein Patients:** Gather, digitize, and organize my medical records that you may already have.

_______ **Insecure, Timely, and Limited Communication Acknowledgement:** I understand and acknowledge that e-mail, text, and some phone conversations are considered insecure under HIPAA privacy laws. The Practice cannot secure in-bound communications that I initiate. I understand and acknowledge that priority or emergency communications must be made via voice phone call and that any other form of communication may take several business days before being received. Additionally, I understand that if I release my information or make public commentary, in most cases, no response will be provided since HIPAA law prohibits the Practice from acknowledging patients in a public forum.

_______ **Contact Method and Entity Acknowledgment:** I understand and acknowledge that my address, phone number, and or e-mail may be used as contact methods for the purposes of clinical care and or informative information. I understand that I may be contacted based on my selected contact interests at any point in the future by our Providers, the Practice, and or associated clinical parties (labs, referrals, etc.) as per HIPAA guidelines and HIPAA privacy protections.

_______ **Photography, Videography, and Recording Devices Privacy Acknowledgement:** I understand and acknowledge that any photos or videos taken by the Practice are protected under HIPAA law. Some procedures, such as cosmetic and or elective procedures, require photos per office policy in order to provide care. The release of videos or photos by the Practice requires my written consent. The use of personal photography, videography, and or recording devices by patients is forbidden. I understand and acknowledge that the use of these devices and or in conjunction with social media puts other patients' privacy at risk and may lead to a breach of privacy under HIPAA law. The Practice, its facilities, and its staff do not consent to being captured or recorded by any photography, videography, and or recording devices under any circumstances unless written approval by the practice manager is obtained in advance.

_______ **Telemedicine Acknowledgement:** I understand and acknowledge that the Practice provides telemedicine in accordance with HIPAA guidelines should I choose to schedule a telemedicine appointment. Telemedicine has been found to be effective in treating many disorders and conditions, however; there is no guarantee that treatments will be effective due to inherit limitations in video technology and the inability to perform physical procedures such as, but not limited to, injections, destructions, and biopsies etc.

_______ **Patient Dismissal Acknowledgement:** I understand and acknowledge that the Practice is committed to service and reserves the right to dismiss patients for breaking office policies. Examples include, but are not limited to, financial negligence, abuse of staff, falsification of information, non-compliance with a care plan, unauthorized use of personal recording devices, and or derogatory or defaming commentary. In extreme cases, the Practice reserves the right to seek damages.

SIGNATURE

I understand that my signature below confirms that I have reviewed and agree to the privacy, financial, and office polices of the Practice.

______________________________	______________________________	______________
Patient, Guardian, or Responsible Individual Signature	Patient Name	Date Signed