



Patient Name _____ Date of Birth ___/___/___

RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION
Effective date May 1, 2018

I have received, understand and consent to this practice’s Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

I ACKNOWLEDGE AND AGREE THAT NO AMENDMENT TO THIS FORM IS PERMITTED. I MAY REQUEST AMENDMENTS TO MY MEDICAL RECORDS IN ACCORDANCE WITH STATE AND FEDERAL LAW AND REGULATION.

With this consent, Dermatology + Aesthetics or our agents may call my home, cell or other alternative location and leave a message on voicemail or in person, including but not limited to, appointment reminders, billing items, and any calls pertaining to my care.

Signature of Patient or Authorized Agent

Date

FINANCIAL POLICY - Effective date May 1, 2018

This form will be immediately scanned and shredded for confidentiality.

General Dermatology Services: Dermatology + Aesthetics participates in many insurance plans. A list of the plans we accept is available on our website www.chicagoderm1765.com under the “Patient Resources” link.

If you are covered by one of our accepted insurance plans, and can provide a valid insurance card or other evidence of coverage at the time of service, we will bill your insurance carrier for your non-cosmetic dermatology services. These dermatology services may be applied towards your deductible, subject to copayment or coinsurance, in which case will be your financial responsibility. If you fail to pay your insurance premium you will be responsible for all services. If you participate in an insurance plan that we accept, you grant us permission to bill your insurance company for the non-cosmetic services rendered and authorize payments of medical benefits to Dermatology + Aesthetics. Please note that Dermatology + Aesthetics does not bill “preventive or wellness care” codes.

Illinois State law requires insurance carriers to pay claims within 30 days of reception. Insurance carriers who fail to comply with these state standards are subject to additional requirements and penalties. When in situations when your insurance provider pays its portion and leaves you accountable for the remaining balance, you will be accountable to submit this payment within receipt of (2) billing statements. When however, your insurance provider delays or withholds payment, for 90 days or longer, both the insurance and patient portions will become your responsibility. If no payment is received your account will be considered past due and you payment will be charged to your cred card information on file with Dermatology + Aesthetics. If the credit card information you provided declines, you will be notified. If you do not contact us, your account balance is subjected to be turned over to a collection agency.

We suggest you monitor your account by calling our Billing Department at (773) 276-1100 option 8. Closely follow balances aging beyond 30 days, at which time we recommend requesting a “claim status report” directly from your insurance carrier. Once you receive a statement, you can also manage and monitor your account online on our website.

If you are not covered by one of our accepted plans, you must pay in full at the time of service. Many insurance plans do provide reimbursement for “out-of-network” care. Please contact your insurance company as to how to submit a claim form and the rules governing visits to out-of-network physicians.

It is our standard of care to exclusively use Healthlab or CPC Laboratories for biopsies and lab work in order to ensure accurate results. We will not send biopsies or lab work to any other laboratory. Depending on your insurance carrier you may receive a separate billing statement for your portion of pathology services directly from Healthlab or CPC.

If your insurance carrier requires you to use another laboratory you may choose not to have lab work done here. We will provide you with a physician's order and you may go to the lab of your choice. Be sure to tell a clinician if you do not want your blood drawn or samples taken here at our office.

Cosmetic Dermatology, Aesthetic Services & Products, and Wellness Visits & Acupuncture: Because they are not considered medically necessary and therefore not covered by insurance plans, full payment is required at the time of service for any retail products, cosmetic services, aesthetic treatments, acupuncture, and/or wellness visits. Cosmetic services include, but are not limited to: Cosmetic Consultations, Botox, Dysport, Fillers, Laser Hair Removal, Microneedling, Photorejuvenation, Diolite, DOT, Pelleve and LED. Aesthetic services include, but are not limited to: Chemical Peels, Micro Dermabrasion, Dermaplaning, Exfoliation and Facials. A financial quote for each individual cosmetic and aesthetic service will be provided during a consultation. This quote will be valid for 90 days. If in addition, any medical decision making is provided for anything other than these cosmetic services, a fee for service will be assessed.

Cosmetic Consultations are designed for our patients to receive the optimal cosmetic treatment and skincare recommendations based on a thorough assessment of each patient's unique needs, health history and cosmetic goals. Important pre- and post-treatment instructions will be provided when necessary. Treatment costs will be quoted at the time of consult. Each Cosmetic Consultation has a service fee of \$100.

Cancellation Policy: If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24 hour notice. In the event that you are unable to give us such notice you will incur a no-show or last minute cancellation fee of \$25 for general dermatology appointments, a fee of \$50 for any cosmetic or aesthetics appointments, and a fee of \$100 for any injectables, wellness, surgical procedures or acupuncture appointment. Our office will accept cancellations during office hours by voice mail, if received 24 hours prior to your appointment. This courtesy on your part will make it possible to give your appointment to another patient who needs it.

Agreement to Financial Policy:

Please remember we directly bill insurance for each patient account as a courtesy. We will make a very best effort to work with each patient and their insurance provider to reconcile any payment disputes; however there is a limit to the services we can provide due to the high administrative cost involved. We strongly suggest you monitor your account carefully. We will ensure our best effort to make this a smooth process.

For continuity of care with our practice, we require that you maintain a valid credit card in our PCI compliant secure database. We understand your concerns with providing us this confidential information but assure you that this information is kept confidential. Alternatively, you may provide a \$150 deposit per visit.

Check only one option:

Credit Card Options (Please only choose one):

- Statement Option:** I will receive *two statements* from Dermatology + Aesthetics. If no payment is received, then my credit card information provided will be processed for my balance on my account **30 days following my second statement** and an email receipt will be sent to me.
- Automatic Bill Pay:** I do not need a statement mailed to me for any outstanding balance(s). I grant Dermatology + Aesthetics permission to charge my card on file for all outstanding balances and email me a receipt.

Cash Option:

- Deposit:** I will leave a \$150 cash or credit card deposit per visit. I will be balance billed for any remaining balance or refunded if I overpaid on my account. Patients with over 4 visits per month may keep a floating deposit on file.

Self-Pay Options:

- I am a Self-Pay or a Cosmetic only patient and will pay full balance at time of service. If I do not pay my balance in full at the time of service for any visit, I understand that I will need a credit card on file prior to booking any future appointments.
- I am a Self-Pay or Cosmetic patient and would like to leave a credit card on file.

I have read, understand and agree to this policy. (Parent or guardian complete if patient is a minor.)

Print Name

Signature

Date

Credit Card Information

Name of Patient :	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Last	First	MI
Name of Cardholder :	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Last	First	MI
Card Type: <input type="checkbox"/> M/C <input type="checkbox"/> Visa <input type="checkbox"/> Amex <input type="checkbox"/> Discover	Expiration Date: <input type="text"/> / <input type="text"/>		CVV #: <input type="text"/>
Credit Card Number: <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="text"/>	This is a HSA card YES / NO		
Billing Address (Required):	<input type="text"/>		

I hereby acknowledge receipt of services, authorize Dermatology + Aesthetics to bill the credit card I have provided above to keep on file for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

Phone Number: Authorized Signature: Date: