Patient's Name: ______________________________ **Date of Birth:** __________

Agreement to Privacy Practices and Consent for Release and Use of Confidential Information.

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.

I agree to the all the Practice Privacy Policies found here:

https://www.chicagoderm1765.com/wp-content/uploads/2016/06/Notice-of-Privacy-Practices-updated-6.21.2016-2.pdf

Patient Signature: _____________________________ **Date:** ______________________

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 **one statement** 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 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.

Credit Card Information

Name On Card: ______________

Last 4 Digits: ________

Exp: ______________

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.

By signing, I agree to the financial policy found here: https://www.chicagoderm1765.com/financial-policy/

Authorized Signature: ___________________________ Date:______________________