



For the purpose of this consent, DOCS Dermatology Group (“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 health 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 it is my responsibility to provide accurate and up to date insurance information promptly to ensure proper billing. If we are unable to process your insurance claim due to delays in receiving the necessary information, you will be held responsible for any outstanding balances and will need to submit a claim for reimbursement directly with your insurance provider.

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.

If I do not have health insurance, I understand payment is due in full at the time of service and that a driver’s license or other valid identification will be required for my self-pay account. Until insurance

eligibility is verified, the account will remain self-pay and payment will be required at check-in. I acknowledge and understand that I am responsible for all self-pay charges, copays, coinsurance, deductibles, and any non-covered or denied services, including those denied due to medical necessity, diagnosis, or payer-specific conditions (for example, non-allowable diagnosis or missing medical necessity support). Self-pay discounts may be applied to gross billable charges for full-fee services where eligible, but do not remove my responsibility for any balances not paid or denied by my insurance plan. 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 acknowledge that payment may be requested on any outstanding balance when I arrive for care. Patient statements will be sent for balances over \$10.00. If payment is not received after standard billing outreach, the account may be referred to a collection agency and could appear on my credit report. If an account is placed with collections, future appointment scheduling may be paused until the balance has been resolved.

I acknowledge that my balance is due in full upon receipt of my monthly statement, including coinsurance, deductibles, and any non-covered services as determined by my insurance plan. If I am unable to pay the full balance at once, I understand that flexible payment plans are available via the DOCS patient online bill pay page or by contacting the billing department at 866-680-8505.

I also acknowledge that if a personal check is returned due to non-sufficient funds, a \$25 fee may be assessed. Until the returned payment and NSF fee are resolved, additional personal checks may not be accepted. If two checks are returned on the same account, I understand that personal checks will no longer be accepted as a form of payment.

I understand that if I fail to attend a scheduled appointment or cancel with less than 24 hours' notice without rescheduling I will be assessed a no-show fee as follows: Office Visit \$50; Excision Appointment \$150; Mohs Surgery \$250. This policy excludes patients with Medicaid. I understand that any applicable no-show or late cancellation fees will be assessed using my credit card on file. If I do not have a valid credit card on file, I may be required to pay the outstanding fee in full prior to scheduling any future appointments. DOCS Dermatology reserves the right to discontinue seeing me as a patient if I incur three consecutive no-shows.

I acknowledge that patient or guarantor credits will be refunded unless applied to an upcoming appointment or an open insurance claim still in process. I understand that DOCS is committed to working with patients to resolve billing questions, discrepancies, or payment arrangements in a way that is fair, clear, and manageable. If I have questions, I can contact customer service at 866-680-8505 for support.

I acknowledge that if I am covered by a commercial health plan, I will be required to enroll in autopay or provide a \$100 deposit at the time of service. As part of this financial policy, I authorize DOCS to maintain my credit card information securely on file. This card may be used to pay for any patient responsibility amounts not covered by my health insurance, including co-payments, co-insurance, deductibles, and non-covered services.

**I understand that:**

- My insurance company will be billed for services rendered.
- Once my claim is processed, my insurance provider will inform DOCS of any balance due.
- I will receive an email notification of the remaining balance and the amount to be charged to my credit card on file.
- My credit card will be charged 10 days after notification is sent.
- Individual payments will not exceed \$300 per transaction and will be charged every 28 days until the balance is paid in full.
- If a charge to my card is declined for any reason, I agree to provide a new valid credit, debit, or HSA card within 10 business days. If a new payment method is not provided within this timeframe, I understand that a \$25 declined card fee may be assessed.
- I understand that patients with Medicare, Medicare Advantage (replacement plans), Medicaid, and Tricare are exempt from this credit card on file policy.
- I understand that if I choose not to provide a card on file, a \$100 deposit will be required at the time of service, in addition to any applicable co-pays. This deposit may be refunded after insurance has processed the claim, provided that no balance is due.

*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.*

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Patient Name

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Patient Signature

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Date