ANNUAL PATIENT CONSENT AND AGREEMENT

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL CONSENT

I voluntarily consent to care at Sutton Dermatology + Aesthetics (SDA), including routine, diagnostics procedures and medical treatment such as examinations, photographs, therapies and other procedures that my physician, and other physicians and health care providers may deem necessary and appropriate. I understand that no guarantees have been made as to the results of such medical care. I agree to all the terms and conditions as described in this financial and treatment agreement. I understand that some procedures and treatments will be performed by SDA employees, and others by independent practitioners/contractors who are neither employees nor agents of SDA. I hereby consent to the use of telemedicine/telehealth services. I understand the service provider will be at a different location from me. I can decline telemedicine/telehealth services at any time without affecting my right to future care or treatment to which I would otherwise be entitled. SDA personnel will use real time video with audio or audio only to communicate and share necessary details of my medical history, examinations, diagnostic testing and/or results, photographs or other images. The same confidentiality protections that apply to my “in person” or face to face medical care apply to the telemedicine/telehealth service provided. Access to all medical information resulting from the telemedicine/telehealth service will be available as provided by law. I also understand that students, residents, medical trainees and medical company representatives may observe my procedures and treatments, and, when allowed by law and properly supervised by qualified personnel, may participate in performance of such services. I authorize SDA to collect, use and disclose information to a third party engaged in the collection or dissemination of my medication information. In some cases, proper treatment of a medical condition requires continuing treatment or diagnosis over a course of repeated outpatient visits. In such cases, the request, consent, and agreement contained herein apply to all repeat visits and all continuing treatment and diagnosis for the same condition.

FINANCIAL AGREEMENT AND RELEASE

I agree to pay SDA and other health care providers for services rendered to me at the rates now in effect or to become effective during the course of my treatment. It is my responsibility to obtain prior authorization and/or physician referrals if required by my insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of treatment and professional services. I understand that all billings for services are due and payable at the time of service. If there is an overpayment by me or on my behalf, or by my insurance carrier, I direct SDA to apply the overpayment to any other unpaid balances. If there are no unpaid balances the overpayment will be refunded to me.

Insurance card(s) are required to be presented at each visit, or you will be asked to reschedule your appointment

Please note: Some insurance plans apply a co-pay for your office visit and an additional (separate) co-pay for your pathology, surgical procedure, wound checks or in house urine pregnancy tests.

Insurance Plans: Sutton Dermatology + Aesthetics participates with all major health plans. However, an occasional health plan may not offer participation with Sutton Dermatology + Aesthetics. It is your responsibility to check with your insurance provider to confirm which providers participate with your health plan. Some health care plans may not cover services such as removal of benign or non-irritated growths. These services are considered cosmetic/elective and payment is due at the time of treatment. You are responsible for following up with your insurance company regarding payment on your claim. Your insurance is a contract between you and your insurance company.

By Federal Law and Managed Care Contract Law, Sutton Dermatology + Aesthetics is required to collect co-payments, deductibles and co-insurances for each encounter. Penalty for not following requirements could result in the termination and cancellation of medical coverage for the patient.

AGREEMENT OF INSURANCE BENEFITS

I assign to SDA all insurance benefits to which I may be entitled to the extent of professional charges owed to SDA. This assignment includes, but is not limited to, major medical, Medicare and disability insurance proceeds and benefits, and the proceeds of any settlement, structured or otherwise, or judgement awarded for personal injuries caused by a third party. I hereby authorize direct payment of all such insurance benefits to SDA and I agree to pay for any and all charges not paid pursuant to this agreement. I also assign insurance benefits to which I may be entitled, as defined in the previous paragraph, to persons, corporations or other entities providing health care services to me in cooperation with SDA, its staff and employees during my care, whose services are deemed necessary and requested by my treating physician.

MEDICARE SECONDARY PAYER QUESTIONNAIRE (to be completed by Medicare Patients)

Is the patient a Veteran?

☐ Yes ☐ No

If yes, does the patient authorize Sutton Dermatology to bill Veterans Administration?

☐ Yes ☐ No

Is this medical condition due to an accident of any kind?

☐ Yes ☐ No

If yes, was it: Work Related ☐ Yes ☐ No Auto Accident ☐ Yes ☐ No

Injury at Home ☐ Yes ☐ No Other Reason ☐ Yes ☐ No

Details: _____

_____

Is this a medical condition covered by another health plan though the patient's current employer or their spouse's employer? (Other than retiree coverage)

☐ Yes ☐ No

If yes, please provide information to the front office staff.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of all or any part of the contents of my medical record to the following: to persons, corporations or other entities Involved in my medical care or part of my medical care provider team for the purpose of immediate treatment, continuity of care and/or payment for healthcare operations.

TELEPHONE NUMBERS

By providing us with your landline or cell phone number(s), you give your consent for us, our agents, and to our collection agents, to contact you at these numbers, or, at any number that is later acquired by you, and, to leave live, or pre- recorded, or text messages. Messages regarding accounts, billing services, appointments, surveys or marketing material. Providing us a telephone or cell number is not a condition of receiving our services, however.

COMMUNICATION

SDA may communicate information to the following people regarding my care as needed or on an emergent basis:

☐ DO NOT speak to anyone about my health status - ***Leave contacts blank***

Contact Number One:

Type of information

☐ All ☐ Scheduling/Appointments ☐ Medical ☐ Billing/Insurance

Name: _____ Relationship: _____ Phone Number: _____

Contact Number Two:

Type of information

☐ All ☐ Scheduling/Appointments ☐ Medical ☐ Billing/Insurance

Name: _____ Relationship: _____ Phone Number: _____

Contact Number Three:

Type of information

☐ All ☐ Scheduling/Appointments ☐ Medical ☐ Billing/Insurance

Name: _____ Relationship: _____ Phone Number: _____

ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices. The undersigned certifies that he/she is the patient or is duly authorized by the patient to sign this document for the patient that he/she has read and understands the contents stated above, and that he/she agrees to the items noted in this medical and financial consent form. The information which has been provided is true and complete. A photocopy of this medical and financial consent form shall be as valid as the original.

This document was signed by:

☐ Patient ☐ Person Authorized to Consent

Patient Signature/Person Authorized to Consent Signature

Name: _____ Date: _____

Person Authorized to Consent for Patient/ Relationship **if Not Patient**

Authorized Signor: _____ Date: _____

Reason **patient was unable to Consent** and relationship to patient: _____

_____

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Secondary Witness to Signature **if Telephone/Verbal Consent**

Print Name: _____ Date: _____

INTERPRETER DECLARATION (Consent signature must be complete)

I have interpreted the form for the patient or patient and/or the patient's representative in the

(List language) _____language. The form as, completed above, was reviewed in my presence with the patient or patient's representative.

Interpreter's Name: _____ Date: _____

OR

Remote Interpreting Number: _____