



Appointments: Office hours are scheduled by appointment only. In scheduling appointments, it is our intent to see you as close to your scheduled appointment time as possible. Our staff and physicians will make every effort to accommodate urgent add on requests. Please be aware that due to the nature of our surgical practice, emergencies can occur and may cause delays. We allow 15 minutes prior to your appointment time to complete the registration process. Individuals that arrive prior to their appointment times may be seen early, only if the schedule allows. Patients who come at their appointment time will be given priority and will not be punished because another patient came early. If you have been referred to our practice for Mohs surgery, please be sure that we have received the necessary Pathology reports and referral documents.

Cancellations: We reserve your appointment exclusively for you. We request AT LEAST 24 hours notice for cancellation of an office visit, and **48 hours for cancellation of a SURGICAL visit. If a Mohs surgery appointment is cancelled without 48 hours notice a \$200 fee will be assessed. Cancellations for minor surgeries without 48 hours notice will be assessed a \$100 fee.**

Minors: Minors will not be seen without a parent or guardian present. There will be no exceptions granted. Appointments will be rescheduled if a parent does not present at the time of the appointment.

ePrescription History Consent: Our office utilizes ePrescriptions to reduce medication errors and enhance patient safety. One optional feature of this service is the ability to obtain your list of medications from your pharmacy using the SureScripts service.

I authorize the Dermatology & Skin Surgery Institute of North Texas to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Signature: **X** _____

Date: ____/____/____

Patient Photo Release: Occasionally, Dr. Spencer uses photos for patient education purposes, in order for patients to be able to see examples of “before and after” procedures. These photos are typically taken close up, and patient’s identities are not usually easily discernable. Please let us know if you consent for your photos to be used for these educational purposes.

_____ Yes, I allow my photos to be used _____ No, I do not allow my photos to be used

Notice Regarding Payments/Insurance Claims: If we are filing insurance for your visit, we must have all of the necessary information, and if a referral is required, we will need that at the time of your appointment. If we are unable to verify your insurance, or if the necessary referral is not obtained, we will not be able to file your insurance, and payment will be required at the time of service.

The exact amount that your insurance company will pay for your claims cannot be determined with complete accuracy until the claim has been filed to your insurance company and they have processed it. Your office co-pay is due at the time of service. In many cases, the co-pay will only cover the office visit, and any procedures performed in the office may fall to your office surgery deductible/coinsurance. If we can determine with reasonable certainty that your insurance company is likely to leave a balance that is due by patient, we will collect the estimated amount due at the time of service.

If you are paying as a self pay patient, payment is due in full at the time of service. We do give a 20% immediate payment discount for these patients.

We do require that you present your insurance card and a valid photo ID at check in.

Assignment of Benefits: I hereby authorize payment of all health insurance benefits to the Dermatology & Skin Surgery Institute of North Texas, and allow assignee to release all information necessary to secure payment. If I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration, Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: **X** _____

Date: ____/____/____



Notice of Privacy Practices Acknowledgement Form

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS, PA originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS, PA's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS, P A reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS, PA is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS, PA has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information. I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I have been provided and have reviewed DERMATOLOGY & SKIN SURGERY INSTITUTE OF NORTH TEXAS, PA's *Notice of Privacy Practices* dated November 1, 2009.

_____ **X** _____
 Print Name of Patient or Legal Representative Signature of Patient or Legal Representative Date

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Dermatology and Skin Surgery Institute must have my consent. Therefore, I authorize Dermatology & Skin Surgery Institute to disclose my PHI as described on this form, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

_____ Test Results _____ Appointments _____ Surgery Information _____ Billing Information

Name(s) of the person(s) authorized to obtain the above mentioned information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature: **X** _____ Date: ____/____/____

Acknowledgement

I have read and understand the above policies of the Dermatology and Skin Surgery Institute of North Texas.

_____ **X** _____
 Print Name of Patient or Legal Representative Signature of Patient or Legal Representative Date