HILLSIDE DERMATOLOGY

Consent to Contact

I hereby consent to Hillside Dermatology with regard to calling my home, cell phone, business phone or other designated means of communication and leaving a message on my voicemail or in-person in reference to anything that assists in carrying out treatment, payment, and healthcare operations, including but not limited to appointment reminders, insurance items and any call pertaining to clinical care, including laboratory results, medications, and other information relating to treatment.

I hereby consent to Hillside Dermatology with regard to mailing me materials to my home or other designated address, text messaging or e-mailing me regarding marketing/promotional offers, anything pertaining to my clinical care, including PHI and other matters related to treatment, such as appointment reminders and patient statements, or payment for services. I acknowledge that Hillside Dermatology cannot and does not guarantee the privacy, security, or confidentiality of an e-mail message or text message sent or received.

I hereby consent to Hillside Dermatology to have communications with the following people regarding PHI:

1. _____ (relationship) _____
2. _____ (relationship) _____
3. _____ (relationship) _____

Name of emergency contact: _____ (relationship) _____ Telephone of emergency contact: _____

This consent shall specifically include information relating to appointments, after care, and the release of test results.

_____

Signature of Patient Print name Date

_____

Signature of Patient's legal representative (if applicable) Print name Date

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Referral Requirement

Due to contractual obligations with insurance companies, it is the policy at Hillside Dermatology that a valid, non-expired referral must be on file at the time of visit for patients whose insurance requires a referral by their primary care doctor to be seen by a dermatologist. Failure to provide a valid referral can result in denial of the insurance claim and leave the patient responsible for the allowed amount of your visit.

Cancellation Policy

We understand there may be times when you might miss an appointment due to emergencies or obligations to work or family. However, we urge you to contact us 48 hours in advance to avoid being subject to a $50 cancellation fee. Three consecutive no-show appointments will result in no further appointments being scheduled.

Co-Pay Policy

Some health insurance companies require patients to remit a co-pay for services provided. We require patients to remit this co-pay before each visit.

_____

Signature of Patient | Print name | Date

_____

Signature of Patient's legal representative (if applicable) | Print name | Date

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Statement of Patient's Financial Responsibility

We appreciate the confidence you have shown in choosing Hillside Dermatology to provide your healthcare needs. The medical service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify and bill your insurance company on your behalf. However, you are ultimately responsible for payment of our fees.

You are responsible for payment of any deductible and copayment/co-insurance as determined by your contract with your insurance company. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance company. If your insurance company does not hold you responsible for a co-pay or out of pocket expense which you paid to Hillside Dermatology, that amount will be used as a credit toward a future visit or you may request a refund. In signing below, you hereby give permission to Hillside Dermatology to release any information concerning your treatment to insurance companies as deemed necessary for the processing of claims.

In signing below, you acknowledge that you have read the above policy regarding your financial responsibility to Hillside Dermatology for providing services to you. You certify that the information is to the best of your knowledge, true and accurate. You authorize any payment of any insurance benefits to Hillside Dermatology or the physician/provider indicated on the claim, the full and entire amount of the bill incurred by you or the above named patient; or, if applicable any amount due after payment has been made by your insurance company.

_____

Signature of Patient Print name Date

_____

Signature of Patient's guarantor/legal representative (if applicable) Print name Date

HILLSIDE DERMATOLOGY

Consent to Telehealth Visit

Patient Name _____ Date of Birth _____

Reason for Visit _____

The purpose of this form is to obtain your consent for a telehealth visit (or "video visit") with a dermatologist/provider at Hillside

Dermatology. The purpose of the visit is to assist in the diagnosis and treatment of your skin condition. In a telehealth visit, you will interact in real-time with your dermatologist via a secure, online videoconferencing technology. Alternatively, the dermatologist may give you the option of submitting a photo and chief complaint via secured electronic messaging. Your dermatologist will look at your skin during the videoconference or review the photos that you submitted. You will then be given advice about your condition and how to treat and take care of your condition.

All federal and state laws covering access to your medical records also apply to telehealth. No one other than your health care provider can view your photos or other information unless you agree to give them access. You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

Telehealth visit charges are billed and collected in the same manner as regular office visits. Your co-payment will be due prior to your telehealth encounter. Final financial responsibility including deductible and co-insurance amounts will be determined after the claim is filed and processed by your insurance carrier(s).

On March 11, 2020, the World Health Organization declared the COVID-19 viral disease to be a pandemic. As a result of this emergency, a rapidly evolving situation, practice patterns for physicians, physician assistants, and nurse practitioners are shifting to accommodate the need to treat in conjunction with unprecedented guidance from federal, state, and local authorities – which include, but are not limited to, self-quarantines and/or limiting physical proximity to others under any number of circumstances. It is within this context (and with the understanding that this method of patient encounter is in the patient's best interest as well as the health and safety of other patients and the public) that telehealth is being provided for this patient encounter rather than a face-to- face visit. This patient encounter is appropriate and reasonable under the circumstances given the patient's particular presentation at this time. The patient has been advised of the potential risks and limitations of this mode of treatment (including, but not limited to, the absence of in-person examination) and has agreed to be treated in a remote fashion in spite of them. Any and all of the patient's/patient's family's questions on this issue have been answered, and Hillside Dermatology has made no promises or guarantees to the patient. The patient has also been advised to contact our office for worsening conditions or problems and to seek emergency medical treatment and/or call 911 if the patient deems necessary.

By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit or in the electronic submission of any images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your dermatologist/provider and his/her institution or practice from any claims you may have about this advice or the telehealth visit. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any telehealth visits that occur during the one-year period after your signature date.

_____ Signature of Patient or Legal Representative

_____Date