Consents and Financial Policies

Thank you for selecting Core Dermatology, pLLC for the care of your skin! Our doctors and staff are committed to helping you navigate the potentially challenging world of healthcare both clinically and financially. The following is an explanation of our office policies. Please read, initial and sign prior to your visit.

Consent for Treatment: By signing this form you are giving permission to the doctors and staff of Core Dermatology, pLLC to conduct an examination, perform procedures deemed medically necessary and administer treatments and medications as recommended. It is your responsibility to participate in their care by following directions, using medications/regimens as prescribed, obtaining further evaluations as suggested and keeping follow-up appointments as recommended. Above all else, it is your responsibility to communicate with the team at Core Dermatology, pLLC if you have concerns about your condition or the plan prescribed.

I (or the minor under my care) am choosing to be evaluated and treated by Core Dermatology, pLLC during the COVID-19 pandemic. The CDC has indicated the COVID-19 is spread mainly from person-to-person and has also recommended to stay at least 6 feet away from people outside your home. While Core Dermatology, pLLC will follow all recommendations as much as possible, I understand that I am putting myself (and by extension anyone I come into close contact with) at increased risk by visiting Core Dermatology, pLLC. I understand that for many dermatological conditions, telemedicine may be a viable option, but I am forgoing that option if it is applicable to my care. I hereby consent to receive care at Core Dermatology, pLLC and assume this increased risk and hold harmless the physicians at Core Dermatology, the practice (Core Dermatology, pLLC) and any employees of the practice in this regard. I will always wear a mask in the office, unless otherwise specified by a physician or staff member.

Consent for Photography: By signing this form you are granting permission to Core Dermatology, pLLC to take photographs for the purpose of documentation within the medical record.

Consent for Release of Information: By signing this form, Core Dermatology, pLLC is authorized to release a complete record of protected health information (PHI) or individually identifiable health information (IIHI) for the purposes of treatment, payment and other healthcare operations. For further details please refer to the Core Dermatology Notice of Privacy Practices. You may revoke this consent at any time in writing.

Consent for Communication: By signing this form, Core Dermatology, pLLC is authorized to contact you via the preferred method for the practice (e.g. phone, text, email). We may communicate with you to discuss your treatment, payment, or health care operations. This includes, but is not limited to, appointment reminders, insurance items, laboratory results, etc.

Consent for Assignment of Benefits: By signing this form you are assigning all medical and surgical benefits, to include major medical benefits to which you are entitled. You hereby authorize and direct your insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to CORE DERMATOLOGY, pLLC for medical services rendered to yourself and/or your dependents. You understand that you are responsible for any amount not covered by insurance.

Initials:____

Consent for Telehealth:

Telehealth (aka telemedicine) is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

The purpose of this portion of the form is to obtain your consent for a telehealth visit or communication as defined above with our dermatologists (expert skin doctors) at Core Dermatology.

I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s) or Medicare and it is my responsibility to check with my insurance plan to determine coverage. I understand that Core Dermatology cannot change their coding to obtain payment, thus I am responsible for knowing the details/rules of my health plan. I understand that telehealth visits are subject to copays, coinsurance, and deductibles. If my insurance denies the claim as "not covered," I will be held personally responsible for the bill.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

•*It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*

•*Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*

•*Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.* ***If there is technical failure during my scheduled appointment, I will reach out directly to Core Dermatology at 303-355-3000 to arrange another mode of communication.***

I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand that a medical assistant and/or scribe will be listening and assisting the dermatologist providing my care.

Initials:____

Consent for Telehealth (continued):

I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that electronic communication may be used to communicate sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

I certify that I have read and understand this agreement. If I have questions prior to signature, I have the right to discuss them with Core Dermatology BEFORE my appointment with the provider.

I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

Initials:____

Payment Policies

Insured Patients: As a courtesy our office will file your primary and secondary medical claims for you. To do so **we must have a copy of your current insurance card as well as valid photo identification**. We can only bill insurance companies with whom we are contracted or from whom we have prior approval. It is your responsibility to investigate whether your plan requires this step, as well as to ensure that Core Dermatology is in possession of the document prior to your visit.

All copays are due at the time of check in or prior to a telehealth visit. Please remember that each insurance company has a unique fee schedule which will determine the additional amount you may need to pay the physician for services performed. Additionally, not all services are considered covered benefits. It is your responsibility to verify your benefits with your specific insurance company prior to receiving services. Patients are responsible for all fees not paid by their insurance company.

***If you are insured but fail to provide insurance information or do not have the required referral to be seen in our office, you will be considered self-pay. You are responsible for paying the full amount for all services at the day of service. You also have the option to reschedule your appointment.

Self-pay: We offer self-pay options for those individuals who do not have insurance or who have a commercial insurance plan with which we are not contracted. Please contact our office manager to see if you are eligible.

Payment methods: Core Dermatology, pLLC accepts cash, CareCredit, checks and all major credit cards. There will be a $50 charge for returned checks or Non-Sufficient Funds.

Refund Policy: Accounts with $50 or less overpayment will retain a credit to be carried over to any future visits. Any excess >50.01 will be refunded to the patient by check.

Missed Appointment Policy: Our practice maintains a 24-hour cancellation policy. If no notice is given prior to this window, a $30 charge may be applied. Patients who no-show 3 times may be discharged from the practice. COVID-19 related absences are currently excused from this policy, although advanced notification is still greatly appreciated.

New patient deposit: New patients may be charged $30 at the time of booking to hold their appointment. This fee is applied to the visit copay/bill. The $30 fee is non-refundable if the patient cancels within 24 hours of the appointment, or if the patient no-shows.

Surgical/cosmetic patient deposit: All patients scheduling a surgical excision, Mohs surgery, and/or cosmetic procedure may be charged $75 at the time of booking to hold their appointment. This fee is applied to the visit copay/bill. The $75 fee is non-refundable if the patient cancels within 24 hours of the appointment, or if the patient no-shows.

Initials:____

Minor Patient Policy: Legal guardians are highly encouraged to attend their child's first appointment to Core Dermatology, pLLC, in addition to as many others as possible. We are legally unable to see children without signed consent from a legal guardian obtained in advance of the visit. Please refer to our website www.mycorederm.com for this consent form.

Laboratory Services and Results: Core Dermatology, pLLC uses outside laboratories for biopsies, cultures, and other tests. You may receive a separate bill from the laboratory used. Every effort is made by our staff to inform you of their results in a timely manner, but if you have not heard from Core Dermatology, pLLC in 7-10 days, it is your responsibility to call the office.

Billing for In-office Procedures: During your office visit you and/or your doctor may determine that a procedure is required to achieve a certain result. Examples of common dermatology procedures are biopsies (e.g., to help determine the biologic potential of a lesion or help diagnose a rash) or destructions (e.g. freezing, snipping, or burning lesions to remove them from the skin). These procedures are billed separately in addition to the bill for the general evaluation of your skin (aka the office visit charge). Some procedures are covered by insurance, and others are not. Please feel free to discuss the estimated cost with your doctor PRIOR to having the procedure performed. Many procedures are not urgent and can be postponed if you would like to check with your specific insurance company in advance. Your doctor will be happy to provide you with anticipated billing codes to the best of their ability.

Patient agreement: I have read the above form and agree to the terms stated. I hereby acknowledge receipt of Core Dermatology, pLLC's Consents and Financial Policies. I realize that payment is my obligation regardless of insurance or third-party involvement.

Patient or Legal Representative Signature: _____

Print Patient Name or Legal Representative Name: _____

Date: _____

Initials:____

Patient Privacy Policy Notice
Effective Date: March 1, 2019

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing (including text and email), to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

425 South Cherry Street, Suite 907• Denver, CO 80246
tel • 303-355-3000 fax • 833-615-8210 email • hello@mycorederm.com
www.mycorederm.com

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstance, except as required under HIPAA. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of March 1st 2019 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer at 303-355-3000 for more information, in person or in writing. All requests related to release or evaluation of PHI must be made in writing and addressed to the Practice Compliance Officer.

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Privacy Policy Acknowledgement
Effective Date: March 1, 2019

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of **Core Dermatology, pLLC**. I hereby acknowledge receipt of **Core Dermatology, pLLC's** Notice of Privacy Practices.

Name [please print]: _____Date of Birth:_____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____[patient name/date of birth]

I hereby acknowledge receipt of **Core Dermatology, pLLC's** Notice of Privacy Practices with respect to the patient.

Name [please print]: _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

DOCUMENTATION OF GOOD FAITH EFFORTS
(for use by staff only when acknowledgement cannot be obtained from the patient.)

The patient presented to the office on _____and was provided with a copy of Core Dermatology pLLC's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign ☐ Patient was unable to sign or initial because: _____
☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at next available opportunity. ☐ Other reason (describe)_____

Signature of Employee Completing Form:_____Date:_____