Dermatology Center of Williamsburg

Office Financial Policy and Consents

Basic Policy – Payment for service is due in full at the time service is provided.
For Patients with Insurance – Co-Payments are due at the time of service.
Returned Check Policy – There will be a $40.00 fee for a check returned by the bank for any reason.
Missed Appointments – I understand that if my appointment is canceled without a 48 hour notice OR if it is deemed a "no show", I will be charged a $50.00 fee. I also understand that repeated occurrences may result in my release from this practice.
Payments on Account – I understand that the following applies to balances accrued on or after April 1, 2013: I understand that any balance due that is not paid within 60 days will be turned over to a collection agency and will be increased by 50% for any recovery fees incurred by this process.
Authorization and Release – I request that payment of authorized insurance benefits be made on my behalf to DERMATOLOGY CENTER OF WILLIAMSBURG for any services rendered to me. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the release of medical information about me to my insurance company or Worker's Compensation carrier that is necessary to determine benefits or the benefits payable for related services.
Privacy Practices Acknowledgment (HIPAA) – I have received and been given the opportunity to review the privacy practices and understand that it will expire one year from today's date. (Reading material is located on the end table)

Patient Record of Disclosures – I wish to be contacted in the following manner (check all that apply)

HOME: _____ WORK: _____ CELL: _____

☐ OK to leave a message with detailed information ☐ Leave a message with call-back number only

Written Communication – I wish to be contacted in the following manner (circle all that apply)

☐ OK to mail to my home address ☐ OK to fax to this number: _____.

Community Exchange: I authorize Dermatology Center of Williamsburg to use any means of electronic transmission to any Healthcare professional, Hospital, or Healthcare Facility to exchange my Protected Health Information.
Medication History: I authorize Dermatology Center of Williamsburg to obtain my Medication History from SureScripts, an E-Prescribe Clearinghouse. The Medication History will include Medications prescribed by all Healthcare Providers.
Patient Referral: I authorize Dermatology Center of Williamsburg to provide an electronic or paper copy of Summary Care Record for each transition of care to another setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long term care, home health, and rehabilitation facility) or provider of care or refer their patient to another provider.
Consent for Care: I authorize all staff of Dermatology Center of Williamsburg to carry out all procedures ordered by my healthcare provider. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion, or handicap. At any time while on the premises of Dermatology Center of Williamsburg, in the event of an emergency, I authorize Dermatology Center of Williamsburg or their employees to provide or obtain such medical treatment as may be deemed advisable under the circumstances.

NOTICED OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner in which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision, the testing would be explained and you would be given the opportunity to ask any questions you might have.

Your signature below signifies your understanding and willingness to comply with the above policies and consent to the Community Exchange, Medication History, Patient Referral, Consent for Care, and consent for HIV blood testing as described above.

Patient Name (**PLEASE PRINT**) _____

Patient Signature _____Date_____