ST. CHARLES COUNTY DERMATOLOGIC SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES And FINANCIAL/BILLING PRACTICE

Please read and initial the following St. Charles County Dermatologic Surgery (SCCDS) Patient PHI Disclosure, the SCCDS financial and billing policy, and sign and date the form.

HIPPA Authorization for Use of Disclosure of Patient Protected Health Information (PHI)

I authorize SCCDS to use or disclose my PHI according to the following scenarios:

1. Tracking my health records, appointments, consults, billing, and treatments in the SCCDS office and sharing with appropriate office staff.
2. Contacting me regarding appointment scheduling, requesting additional appointment information or other pertinent health related concerns. Releasing or discussing my medical information to anyone I have explicitly consented to on the SCCDS Release of PHI form. Providing my medical information as required by law.
3. Providing tissue samples and related information to an outside laboratory if my consult and/or treatment requires.
4. Requesting my medical information from the referring physician's office as necessary for my consult and/or treatment. Updating my referring physician of my consult and/or treatments.
5. Providing my medical information to another physician that I have accepted a referral to from this office.
6. Providing my insurance company the required information for payment of my consult and/or treatment.
7. Providing my employer pertinent medical information for work excuse or limitations.
8. Providing information required by the pharmacist when prescription in relation to my consult and/or treatment.

_____ **Initial to acknowledge you read and accept the SCCDS Patient PHI Disclosure.**

Please read and initial the following SSCDS financial and billing policy:

1. Co-pay and patient responsibilities: All co-pays and insurance determined patient responsibilities are non-waivable and non-refundable. Failure for either patient or provider to comply with their respective insurance contractual agreement is considered fraudulent and punishable by law. Furthermore, failure to comply my result in termination of patient insurance benefits and/or termination for the provider insurance contract.
2. Billing statement processing fee: Any unpaid patient balance after the first billing statement will be subjected to a $5.00 processing fee.
3. Delinquent Accounts: Once third-party payment has been determined, outstanding balances 90 days after the date of service are considered delinquent. If the patient indicates they will not pay and/or defaults on payment arrangements previously established, the account is turned over to a collection agency. If this occurs, an additional 30-50% fee charged by the collection agency as well as any attorney fees or court costs incurred to collect the debt, will be paid by the patient.

_____ **Initial to acknowledge you read and accept the SCCDS Patient PHI Disclosure.**

Patient Name _____ Patient DOB _____

Signature _____ Date _____
(Patient or Legally Authorized Representative)

Relationship (Legally Authorized Representative to Patient) _____

SCCDS Staff Initials_____