PINNACLE DERMATOLOGY
medical | surgical | cosmetic
A Division of Prime Medical Group, PLLC

Patient Name	Date of Birth

Welcome! Please authorize and acknowledge our office policies, privacy practices, and HIPAA form.

- **Identification:** We obtain a copy of a valid State ID and insurance card from each patient. This information is obtained for verification purposes. If the patient is a minor, a parent or legal guardian's ID will be obtained.
- **Insurance:** Charges will be filed at the patient's request. Copay, coinsurance, and any deductible not met are due at the time of service. If you have questions about your coverage, it is your responsibility to contact your insurance company before your appointment. You are financially responsible for any charges not covered by your insurance. We collect at the time of service based upon the information we obtain from your insurance company.
- **Lab and Pathology:** Labs will be billed separately by Quest Diagnostics or LabCorp. Pathology will be billed by PRIME MEDICAL GROUP. It may be necessary for us to send your pathology specimen to an outside lab and a separate bill will be sent to you.
- **Referrals:** If your insurance provider requires a referral, it is ultimately the patient's responsibility to obtain the referral from their primary care physician. Please call ahead to ensure we have your referral to avoid delays or having to reschedule your appointment.
- **Uninsured Patients:** Payment in full is expected at the time of service. A Good Faith Estimate will be sent to you before your appointment.
- **Non-Covered Charges:** All non-covered charges not payable by your insurance company are the patient's responsibility and due at the time of service.
- **Cosmetic Procedures, Services, and Products:** Can not be filed with your health insurance and are payable in full when services are rendered. All sales are final, non-transferable to another person and not eligible for trade or exchange. Pre-purchased products and services expire one year from the date of purchase unless otherwise noted.
- **Returned Checks:** There will be a $30.00 charge for all returned checks.
- **Late-Cancellation and Missed Appointment Policy:** We ask that patients who are not able to keep their appointments provide us with *24-hour advance notice* to allow other patients to be seen. If notice is not provided, I agree to pay a $50 fee for office visits and a $75 fee for excision/surgery procedure appointments before scheduling another appointment. This fee is not covered by insurance and is not eligible for reimbursement with an HSA or FSA account. If you are running more than 15 minutes late for your appointment, we may need to reschedule your appointment.
- **Changes in my Health Insurance or Health Status:** I agree to notify the clinic of any changes.
- **Notice of Privacy Practices – Acknowledgement of Receipt: By signing below**, I acknowledge I have been provided with the opportunity to review and obtain a written copy of the Pinnacle Dermatology, Prime Medical Group Notice of Privacy Practices. The Notice describes how your health information may be used or disclosed. The Notice may be changed, and you may obtain a revised copy at any time.
- **Authorization to Release Information to Family Members and Friends:** You have the right to identify family, friends, or others to receive medical or payment information about you. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. **I authorize Pinnacle Dermatology, a division of Prime Medical Group, to release my protected health information to the following individuals:**

Name	Phone Number	Relationship to the Patient

☐ **I DO NOT WISH TO GIVE AUTHORIZATION TO ANYONE**

I understand that I have the right to revoke my authorization at any time except where Pinnacle Dermatology has already made disclosures in reliance upon this consent. **This authorization will remain in effect until I change or revoke consent, in writing, unless I specify a different expiration period**: _____

If patient is a minor, consent will expire when the minor reaches 18 years old.

If you are signing on behalf of the patient, please fill out the following information:

Name _____ Relationship to the Patient _____ Phone Number _____

Address _____ ☐Same as Patient

If applicable, please furnish a copy of conservatorship/guardianship papers prior to the appointment.

By signing below, I confirm that I have read, authorize, and agree to the information above.

Signature of Patient/Parent/Legal Guardian _____ Date _____