Colorado Dermatology Institute

Informed Consent

Revised March 2019

Consent for Treatment: By signing this form, I authorize Colorado Dermatology Institute's (CDI) practitioners and staff to evaluate and treat me to include but not limited to: biopsies; excisions to include Mohs surgery, shave excisions and removals; Electrodessication and Curettage (ED&C); liquid nitrogen cryosurgery; intralesional injections; intramuscular injections; Superficial Radiotherapy (SRT); and Photodynamic Therapy (PDT). All procedures will be fully explained to me prior to treatment and as with any treatment plan, I understand it is my responsibility to follow the recommended treatment plan and that there are potential risks involved. The most common risks are, but are not limited to: scarring (any procedure can produce a permanent scar); infection; bleeding; reaction to anesthesia; pain; nerve injury resulting in no sensation or movement in the surround area; blood vessel injury which could cause localized death of skin and tissue; allergic reactions; and/or potentially life threatening reactions to surgical procedures.

How we may use and disclose Protected Health Information (PHI): By signing this form, you understand we may use and disclose PHI that identifies you and the health condition(s) for which you are being treated. You may revoke such permission at any time by writing to the Privacy Officer at 8580 Scarborough Dr., Suite 225, Colorado Springs, CO 80920. Please refer to CDI's Patient Privacy and Protected Health Information policy on our website for the complete policy. You have a right to a paper copy of this policy by requesting this from our Privacy Officer. Except for the purposes described below, we will use and disclose PHI only with your written permission:

- *Treatment:* We may use and disclose PHI for your treatment and to provide you with treatment related health care services. We may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
- *Payment:* We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.
- *Health Care Operations:* We may use or disclose your PHI in order to support the business activities of your physician's practice. The activities include, but are not limited to: quality assessment activities; employee review activities; training of medical students; licensing; and conducting or arranging for other business activities.
- *Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services*: We may use and disclose PHI such as your name, email address, physical address or phone number to contact you to remind you that you have an appointment with us. We may mail out reminders of upcoming appointments. I understand that these reminders will be in a postcard format which will allow anyone who sees that postcard to know that I have a dermatology appointment with no further detail. We also may use and disclose PHI (name, email, address, phone number) to tell you about treatment alternatives or health related benefits and services that may be of interest to you.
- *Individuals Involved in Your Care or Payment for Your Care*: When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a legal representative and/or guardian. If you are a UCHealth patient we may upload your office visit notes to UCHealth's electronic health record system, Epic, to allow your dermatology records to be viewed by your providers in the UCHealth network.
- *Research*: Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition.

Financial Obligations: Payment is due in full at the time service is provided by CDI. We accept cash, personal checks, debit and credit cards to include Care Credit. We will bill all insurance carriers with the insurance information you provide. Co-payments are due at the time of service. Although we are contracted with most insurance carries, it is the patient's responsibility to ensure we are covered with the patient's insurance plan.

Once your claim has been processed, any outstanding balance will be your responsibility. For uninsured patients payment will be due in full at the time of service or pre-approved payment arrangements with our billing department.

CONTINUED ON REVERSE

Colorado Dermatology Institute

Additional information in regards to your financial obligations:

- *Referrals:* Proper insurance documentation and any required referrals (to include Tricare) or required pre-authorizations is the responsibility of the patient. In the absence of appropriate referrals or pre-authorization, you agree to accept full responsibility for any charges related to the services performed by CDI. Additionally, if services are rendered which are outside the scope of your referral or authorization, you accept full responsibility for these charges.
- *Laboratory Fees:* You may be referred to an outside laboratory for tests. These fees will be billed to your insurance or to you by the laboratory. It is the patient's responsibility to use a laboratory contracted by your insurance provider. If a tissue sample needs to be read by a dermatopathologist, you may be charged and be responsible for those additional services.
- *Authorization for Release of Medical Records:* I authorize the release of medical records and information necessary to process insurance claims for medical and surgical benefits.
- *Minor Patients:* The accompanying parent/legal guardian of the minor child will be responsible for payment at the time of service, and for the minor's account balance.
- *Delinquent Accounts and Collections:* If a patient has not made payments on their account for 90 days, that account is considered delinquent and the patient will not be scheduled for any future appointments until the account is current. Delinquent accounts may be turned over to a collections agency, and you understand that you will be charged for, and herby agree to pay, all costs and expenses incurred in collecting any past due fees.
- *Return Check Fee:* We will charge a $35.00 fee for returned checks.

Missed Appointments: If you need to cancel your scheduled appointment we require 24 hour notification (one business day) for non-surgical appointments, and 48 hour (two business days) for surgical appointments. Patients may be charged $75.00 for a missed appointment for non-surgical appointments, and $250.00 for missed surgical appointments. If a missed appointment fee is applied, future appointments will not be scheduled until the missed appointment fee is paid in full. If you miss two appointments within a 12 month period and/or do not comply with the appropriate cancelation notification procedures as listed above, we may not continue to see you as a patient.

Taking of Photographs: I consent to the taking of a series of photographs along with pertinent information pertaining to these pictures for my practitioner's use for: documenting your medical records; educational lecturing; or submittal to appropriate sources for research purposes.

Consent to Leave Details of Biopsy Results on My Telephone Voicemail: I consent to CDI leaving results of biopsies on my telephone voicemail. I understand that CDI cannot control who would hear these voicemail messages.

Consent to Contact via Email: I acknowledge CDI will contact me via unencrypted email with the email address I listed for the following reasons: appointments; for access to the Patient Portal to view my Medical Records; to receive biopsy results; for insurance/financial matters; to give information about products and services; and to receive our monthly Newsletter (which you can opt-out of anytime).

With your signature, you verify that you have read, understand, and agree to comply with the above consents and policies. If you do not sign agreeing to these consents and policies, CDI may decline providing you medical treatment.

_____	_____	_____
Patient's Name (Please Print)	Date of Birth	Last 4 of SSN
_____	_____	
Signature of Patient/Legal Representative	Today's Date	
_____		
Legal Representative's Name (Please print)		