BLUE OCEAN DERMATOLOGY

Patient Consent Form

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	SSN	DATE OF BIRTH	SEX

STREET ADDRESS

CITY	STATE	ZIP CODE	HOME PHONE	CELL PHONE

New Patient Consent – NP

Consent for Treatment

A. Consent for Treatment: I give consent to my physician, other attending physicians, nurse practitioners, physician assistant and their assistants and designees at Blue Ocean Dermatology, LLC to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction; including skin biopsies, x-ray, laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I give consent for my physician, other attending physicians, nurse practitioners, physician assistant and their assistants and designees to formulate a medical treatment plan and to perform that treatment plan as they deem necessary. I understand that these plans may include, but are not limited to, topical medications, oral medications, injectable medications, electrocautery and desiccation, superficial radiation therapy, surgical excision, and/or phototherapy.

B. General Acknowledgments: I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at my physician's office. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

C. Assignment and Agreement to Pay: I understand that I am responsible for payment of the services I receive and guarantee payment for these services. I hereby assign to Blue Ocean Dermatology, LLC, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of physicians and/or the professionals associated with an office practice. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payors, or others for billing purposes. In addition, I understand that I may receive separate bills from independent physicians or laboratories involved in my care; including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks. I understand that if I do not have medical insurance, I am responsible for the payment of services on the day services are rendered.

D. Insurance Acknowledgment: I acknowledge that it is my responsibility to understand the benefits of my insurance plan and its requirements when seeking treatment and/or care not provided by my primary care provider.

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E. Personal Valuable: I understand that Blue Ocean Dermatology shall not be responsible or liable for the loss of or damage to any personal property.

F. Privacy Notice: I acknowledge that I was provided with and/or offered a copy of the Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

I have read this form and my questions have been adequately answered and I certify that I understand its contents.

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Patient Financial Policy

Thank you for choosing Blue Ocean Dermatology, LLC to serve you and your family's health needs. We are pleased to participate in your family's health care and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. Your medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Blue Ocean Dermatology, LLC. All patient responsibilities are to be paid at the time of service.

Your co-payment will be collected on the date of service. Any deductible, co-insurance, or full payment is due at the time services are rendered. We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans.

For your convenience we accept cash, personal checks, most major credit and debit cards as an extended payment option. If you cannot provide a current medical insurance card or do not have medical insurance, full payment must be made at the time services are rendered.

It is your obligation to make certain that this office is a participating provider of your policy and that referral information and authorization has been obtained in advance of your appointment. We will file your insurance claims for you if all necessary information is received at the time of your visit. It is also your responsibility to inform our office of changes in insurance coverage and/or personal contact information.

If payment is not received from your insurance company within 45 days, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. An account for which no payment is received within 60 days and for which no payment arrangements are made may be sent to a collection agency. The balance will accrue a monthly interest fee and an additional fee for the expenses related to collections. Checks returned to our office for nonsufficient funds (NSF) will incur a $30 service charge.

Self-pay accounts are patients without insurance coverage or patients without a current insurance card on file with us. If there is a discrepancy with insurance information provided to us by the patient, the patient will be considered self-pay until the correct information is provided. Self-pay patients will be required to make payment at the time of service or the make payment arrangements for their balance. Extended payment arrangements are available if needed, but the minimal monthly payment is $100.00, unless the balance is of a lesser amount. Please ask to speak with a Financial Counselor to discuss a mutually agreeable payment plan.

Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. We do understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, if two (2) appointments are missed without notice there will be a $25 fee charge. Appointments set for cosmetic or aesthetician services not cancelled 24 hours in advance will automatically be charged $25. Three missed appointments are subject to dismissal from the practice. Families (three or more), who miss their same-day scheduled appointments and fail to provide a minimum of 24 hours' notice, unduly inconvenience the practice and will incur a mandatory $50 service charge.

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We try to utilize contracted laboratories for biopsies. When skin growths are biopsied or removed, there are two separate charges. First there is a charge for the actual biopsy/removal performed. Second, there is a lab charge for preparing and examining specimen slides under a microscope. Lab charges occur on a different date. If the specimen slides require a second opinion or special stain, an independent lab will bill your insurance carrier for additional fees. If you have questions about these additional lab fees, please contact the lab directly as these fees are not charged by our office.

Unaccompanied minors must have a consent signed by a parent or guardian. Non-emergency treatment will be denied unless non-covered charges and co-pays have been paid and insurance billing is approved under the insured's policy. Co-pays and other charges can be paid via telephone by credit card.

Should you request copies of your medical records, there is a fee charged as allowed by current Florida statutes. There is also a cost associated with

your request for physician "narrative reports" and/or letters not related to our insurance claims. These fees would be based on the complexity and amount of time involved.

Our staff will be happy to answer any questions you may have about our policies. Thank you for allowing us to serve you.

I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Blue Ocean Dermatology, LLC. I authorize the release of medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

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Nurse Practitioner/Physician Assistant Consent

This facility has on staff a nurse practitioner and/or physician assistant to assist in the delivery of medical care. A nurse practitioner or physician assistant are a graduate of a certified training program and is licensed by the state board. They are board certified and are required to participate in a designated number of hours of continuing medical education each year to maintain that certificate. Under the supervision of a Physician, a nurse practitioner or physician assistant can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provided.

I have read the above, and hereby consent to the services of a nurse practitioner or physician assistant for my health care needs. I understand that at any time I can refuse to see the nurse practitioner or physician assistant and request to see a Physician.

This consent may be withdrawn only in writing and shall not be deemed withdrawn until such time as Blue Ocean Dermatology, LLC receives actual written notice that I have withdrawn my consent as stated above. This consent shall remain in effect until revoked in writing by the undersigned.

_____	_____	_____	_____
Witness Signature	Date	Patient / Agent / Guardian Signature	Date