Drs. Ford & Rothman, Cosmetic and Clinical Dermatology, LLC

PATIENT POLICIES

As a patient of Drs. Ford & Rothman L.L.C. and Associates I understand it is my responsibility to provide accurate and complete information regarding my medical needs, medical history, medications, demographics, and health insurance.

- It is my responsibility to provide proof of identification (driver's license) and current insurance information prior to or upon arrival for my appointment (parent's information in cases of a minor).
- It is my responsibility to sign a HIPAA Privacy Act acknowledgement statement.
- It is my responsibility to report changes in my medical condition, medications, demographics, or insurance to the physician and/or staff.
- It is my responsibility to request additional information about my medical condition or treatment when I do not fully understand the information or instructions given to me.
- I understand that there is a medical records copying fee and a per page copy fee, as allowed by Maryland Law. This fee must be paid before records will be sent.
- I understand a fee of $35.00 will be imposed for any checks returned due to insufficient funds.
- I understand that my appointment time is reserved for me only and it is my responsibility to give 24 hours notice when canceling an appointment. There will be a $100.00 fee if I fail to cancel a 30-minute appointment without 24 hours notice and $50.00 fee if I fail to cancel a regular 15-appointment without 24 hours notice.
- I understand that it is my responsibility to pay any outstanding balances, insurance deductibles and co-pays at the time of service.
- I understand that payment on all statements is due upon receipt.
- I agree to reimburse the practice the fees of any collection agency, which may be based on a percentage at a maximum of 31% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.
- I understand that it is possible that my insurance company may deem a dermatological procedure as cosmetic (such as removal of skin tags or other benign growths) and I agree to be financially responsible for these charges should this occur.

I certify that the answers to the questions above are true, correct, and complete to the best of my knowledge. I also acknowledge and accept the patient policies stated above.

SIGNED: _____ DATE: _____

PRINT NAME: _____

18310 MONTGOMERY VILLAGE AVENUE, SUITE 700, GAITHERSBURG, MD 20879
PHONE: 301-977-2070 * FAX: 301-330-9452

Drs. Ford & Rothman, Cosmetic and Clinical Dermatology, LLC

18310 Montgomery Village Avenue, Suite 700, Gaithersburg, MD 20879

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, CCCD may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to CCCD Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CCCD at 18310 Montgomery Village Avenue, Suite 700, Gaithersburg, MD 20879.

With my consent, CCCD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, CCCD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, CCCD may e-mail or text to my phone or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that CCCD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CCCD use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, then CCCD may decline to provide treatment to me.

Date _____

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian