TUCSON
Dermatology
Dermatology, Mohs Surgery, & Cosmetics

Acknowledgement and Consent

____ (Initial) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**
I, (print patient name) ____________________________, have read a copy of Tucson Dermatology's Notice of Privacy Practices. (This document is available at the front desk or at tucsondermatology.com.)

____ (Initial) **CANCELLATION POLICY**
In fairness to other patients and your doctor, we require at least 24 hours' notice to cancel appointments. If you cancel with less than 24 hours' notice or miss your appointment, a $50 fee may be charged. This fee is not covered by insurance; it will be your responsibility to pay. Please help us serve you better by keeping your scheduled appointment.

____ (Initial) **RELEASE OF MEDICAL INFORMATION/CONTACT PERMISSION**
In the event that Tucson Dermatology needs to contact you regarding medical information about an appointment, lab/biopsy result, medication, or any other reason, it is permissible to release your information:
☐ Leave a message on an answering machine
☐ Speak with spouse/significant other Name: ________________________

Phone number: __________________
☐ Speak with other family members Name(s): ________________________

Phone number: ___________________
OR - I DO NOT authorize Tucson Dermatology to release any medical information to anyone. ____ (Initial)

____ (Initial) **PATIENT PORTAL**
I Do / Do Not authorize Tucson Dermatology to publish my benign results to my patient portal.

____ (Initial) **INSURED FINANCIAL RESPONSIBILITY**
I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Tucson Dermatology for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if any procedure is considered cosmetic per my insurance policy or not paid in a timely manner. All procedures are subject to any applicable copays, deductibles, and/or

coinsurance. Additionally, I acknowledge that a $50 fee may apply to certain services or missed appointments, as outlined in the cancellation policy.

____ (Initial) **UNINSURED FINANCIAL RESPONSIBILITY**
If you do not have insurance coverage, payment in full is due at the time of your visit unless payment arrangements are made prior to your appointment. Any elective procedure will not be performed unless full payment is received at the time of your visit. I acknowledge that a $100 fee may apply to missed appointments, as outlined in the cancellation policy.

Acknowledgment of $50 Fee
By initialing the relevant sections above and signing below, I acknowledge that I am aware of the $50 fee that may be charged for missed appointments or specific services, as specified in the sections on cancellation and financial responsibility.

My signature below indicates that I have read, understood, and agree with all statements initialed above.

________________________________ ________________

Patient Signature **Date**

________________________________ ________________

Guardian/ Parent Signature **Date**