General Consent for Outpatient Services

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Horvath Dermatology Associates
110 Fort Couch Rd., Suite 203
Pittsburgh, PA 15241
P. (412) 831-3300
F. (412) 831-3301
www.horvathdermatology.com

Patient Name: _____ Date of Birth: _____

1) CONSENT TO TREATMENT AND RELEASE OF MEDICAL INFORMATION: I authorize treatment and services for myself or a minor child by Horvath Dermatology Associates. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

2) PAYMENT FOR SERVICES: To establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified, and you will be asked to pay any unmet deductible, non-covered services, and copayments. A twenty-five-dollar fee may be added for all missed appointments and appointments cancelled with less than twenty-four-hour notice. A thirty-five-dollar fee will be added for all returned checks. If your account must be turned over to collections, a ten dollar collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

3) CONSENT TO PHOTOGRAPH: I understand photographs may be taken for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image.

4) ELECTRONIC PRESCRIBING: I authorize SureScripts, an electronic prescribing network, to release my medication history to Horvath Dermatology Associates for the purpose of continued treatment.

5) RECEIPT of NOTICE OF PRIVACY PRACTICES: I am a patient of Horvath Dermatology Associates. I hereby acknowledge receipt of Horvath Dermatology's Notice of Privacy Practices.

6) FOR MEDICARE: This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS), or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

7) FOR MEDIGAP PATIENTS: If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over," we are required to keep a signature on file. Please read the following statement:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier, any information needed to determine these benefits or the benefits payable for related services.

I agree to the terms outlined in this form. The signature below indicates acceptance of the information listed above.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby agree to the terms outlined in this agreement with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____