AESTHETIC LASER SURGERY & DERMATOLOGY, Ltd.

400 N. Main St., Centerville, Ohio 45459 (937) 438-3376

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA),

I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private informatin is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:____**Signature**:____

Relationship to Patient:____________________________________**Date**:____

FINANCIAL POLICY

We are committed to providing you with the best dermatologic care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, financial policy, or your payment responsibility.

We accept cash, checks, VISA/MASTERCARD, American Express and Discover

All patients must complete our "Patient Registration Form" before seeing the doctor.

Please note there are many skin conditions treated by dermatologists that are considered cosmetic by insurance companies and Medicare, and therefore would be the patient's financial responsibilty.

We will inform you if we ar a party to your insruance contract and will handle your claims according to our agreement with the insurance company. Co-payments for insurance companies for which we are a participating provider are due at time of service.

If your insurance company requires a referral from a primary care physician and you do not present one, you will be financially responsible for that service.

We will file your insurance claims for you except cosmetic procedures will not be billed to the insurance company, and must be paid at the time of service.

For all Medicare patients, we will file your claims to Medicare and your secondary insurance. After we receive payment from both there may be a balance due for which you will be billed. Your secondary insurance may not cover your yearly Medicare deductible.

Thank you for agreeing with our financial policy. Please let us know if you have any questions or concerns.

Patient Name:____**Signature**:____

Relationship to Patient:_____________________________**Date**:____