CAROLINA DERMATOLOGY
OF GREENVILLE

Phone: 864-233-6338
Web: www.carolinaderm.com
Address: 920 Woodruff Rd, Greenville, SC 29607

Consent to Medical Treatment:

Carolina Dermatology, PA maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize Carolina Dermatology, PA (Clinic) providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific service, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that Clinic and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by Clinic.

Consent to Recording or Filming.

I authorize Clinic, the attending physician, or other Clinic authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Assignment of Insurance Benefits. Patient Financial Responsibility and Credit Report Authorizations:

I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefits payments or other payment sources directly to Clinic and/or the physicians providing services in conjunction with Clinic. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain Clinic and physician services. I understand I am financially responsible to Clinic and physicians for charges not covered by this insurance assignment, I further understand Clinic can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to Clinic. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us or my/our behalf exceeds the amount due the Clinic, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that l, my spouse, or any child for whom I am financially responsible, may have with the Clinic or any other facility entity related to Clinic.

Authorization to Disclose Information and Privacy Act:

I authorize Clinic, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that Clinic may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below; however, I reserve the right to revoke this authorization at any time by contacting the Corporate Privacy Officer at (770) 285-7910. I understand I have the right to review the Notice of Privacy Practices before signing this consent. I further

Phone: 864-233-6338
Web: www.carolinaderm.com
Address: 920 Woodruff Rd, Greenville, SC 29607

understand that the Notice of Privacy Practices provides a more complete explanation of the uses and disclosures of my protected health Information.

Authorization to Release Medical Information:

I authorize the Clinic and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize the Clinic and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize the Clinic and my physicians to release any. medical information necessary to prove the Clinic's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in In the event of my death, the release of medical information is necessary to verify any charges incurred by me.

Authorization to Release Medicare and Medicaid Information:

I certify that the information provided by me in applying for payment under Titles V, Will and/or XIX 01 the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend dental of payment if my medical condition does not warrant continued Clinic care. I authorize the Financial Counseling Wellness staff of the Clinic to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department 01 Social Services to provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

For Underinsured Patients or Uninsured Patients:

I authorize Clinic and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find to find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/Liability For Valuables:

I understand that Clinic has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve Clinic from responsibility for their loss, damage of disappearance.

Payment Guaranty: (Patient and/or responsible party/parties) agree to pay all charges for services rendered by Clinic and my physicians or other providers during treatment related to services provided by Clinic. This guaranty includes charges not covered by my insurance regardless of the reason insurance coverage is denied.

CAROLINA DERMATOLOGY
OF GREENVILLE

Phone: 864-233-6338
Web: www.carolinaderm.com
Address: 920 Woodruff Rd, Greenville, SC 29607

I agree to pay the reasonable cost of the attorney services in addition to the unpaid charges. I consent and authorize Clinic and its agents or subcontractors to contact outside sources including for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that Clinic may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize Clinic and third-party agents of Clinic to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

I affirm that my signature on this form indicates that I have disclosed any and all current Insurance coverage/s that may pay for this visit. Further, any failure on my part to Identify my insurance/s may result in additional charges for which I win be responsible. My signature also indicates that if I have no insurance coverage J will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.

I have read the request and authorization in Its entirety and agree to be bound by all the terms and conditions herein. Witness my (our) hand(s) and seal(s) below,

_____. _____

Patient Responsible Party(ies)

_____ _____

Witness Relationship to Patient

Spouse____Parent____Other(specify)_____

I have been provided access to Clinic Notice of Privacy Practices

_____

Patient (or authorized representative) Date Time

Patient unable/unwilling to sign_____ Reason _____

Clinic Representative_____

Date/Time _____