FARGO CENTER for DERMATOLOGY
MEDICAL | SURGICAL | AESTHETIC

www.fargoderm.com
Phone 701-478-8780
Fax 701-478-8781

CONSENT FOR CARE AND TREATMENT:

I authorize and give my consent to Fargo Center for Dermatology to furnish medical care and treatment as considered necessary and proper for diagnosis and treatment. This consent includes cryotherapy, cautery, biopsies, excisions, photos used for diagnostic purposes, and other procedures deemed medically necessary by the medical health care provider. I understand that the medical health care provider will discuss with me before any procedure or treatment, and this treatment and care will be documented in my medical record. This consent is valid throughout all treatment for this condition and/or disease process.

HIPAA/GENERAL RELEASE OF PROTECTED HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS:

I Authorize Fargo Center for Dermatology on behalf of myself and/or my dependents, to furnish medical records, and other information related to health care services provided by Fargo Center for Dermatology to Medicare, my insurance company or health management organization, other payers, payer network organizations, in which my providers participate, and file contractors and third-party administrators of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf to Fargo Center for Dermatology for any services furnished by Fargo Center for Dermatology

RELEASE OF PROTECTED HEALTH INFORMATION BY PAYERS AND NETWORKS:

I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third-party administrators to share my health records and information obtained from Fargo Center for Dermatology or any other provider, with Fargo Center for Dermatology, other organizations in which my provider participates, and the contractors and third-party administrators of these parties as needed for payment and health care operations.

RELEASE/RETRIEVAL OF PROTECTED HEALTH INFORMATION TO/FROM HEALTH CARE FACILITIES, PHARMACY BENEFIT PAYERS AND PROVIDERS:

I authorize the release or retrieval of my medical treatment information, including films, prescription medication history, and other information related to such services for health care operations to or from third-party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

PRIOR AUTHORIZATIONS AND REFERRALS:

All services that require prior authorization must be authorized before we provide the service. Additionally, if a referral is needed, it must be obtained before the date of your service.

PHONE MESSAGES:

I authorize Fargo Center for Dermatology to use and disclose medical information to contact me regarding an appointment, possible treatment options, or other benefits or services that may be of interest to me. Fargo Center for Dermatology may call me and, if necessary, leave messages on my answering machine.

TEXT MESSAGES:

I authorize Fargo Center for Dermatology to send me text message reminders and messages about appointments in the office. I understand that I can opt out of these messages at any time.

FINANCIAL POLICIES:

Fargo Center for Dermatology is pleased to participate with many different insurance plans. It is the patient's responsibility to understand and comply with any requirements of your insurance plan/s. Please know that you will be responsible for any payment due (this includes co-payments, co-insurance amounts, and deductibles). Failure on our part to collect this portion of the charges is considered insurance fraud. As a courtesy to our patients, we will bill participating insurance plans if a valid insurance card is provided. If you are self-pay, we offer a cash pay fee schedule for services, and payment is due when the services are rendered. If you choose to self-pay, we will provide you with the legal visit note but will not bill any insurance company or HSA at any time now or in the future. If you have Medicare, allowed charges must be billed through insurance. I understand that Fargo Center for Dermatology is not a provider for Worker's Compensation, and I will be held liable for the total amount of charges for services provided.

CO-PAYS:

All co-payments are due at the time of service.

STATEMENTS:

If my insurance carrier does not remit payment or notification to my provider within 60 days, the balance will be due from me. If my insurance company requests a refund of any payments made to Fargo Center for Dermatology, I will be responsible for any money refunded to my insurance company. In the event my insurance company establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining.

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COLLECTIONS:

Delinquent patient accounts over 120 days may get assigned to a collection agency. When accounts get sent to a collection agency, the additional fees associated with that process will get added to your account balance ($50 minimum up to 50% of total charges). For your convenience Fargo Center for Dermatology accepts cash, checks, Discover, Visa, Master Card, American Express, Care Credit, and HSA cards.

Any returned checks will be assessed a $30.00 processing fee

CANCELLATION/NO-SHOW POLICY:

I understand and agree that if I fail to show for a scheduled appointment or do not notify Fargo Center for Dermatology 24 business hours in advance, I will be charged a cancellation fee of $25.00. For a procedural appointment such as surgeries, cosmetic appointments, laser procedures, etc. I must cancel 48 business hours in advance, or I will be charged a minimum fee of $75.00.

These fees will be required to be paid before scheduling any further appointments in our office. I understand payment on my account for any missed appointments will be my responsibility. We know that things can happen unexpectedly, and we will take individual circumstances under consideration.

PATIENT SIGNATURE AND CONSENT:

By signing or verbally consenting to this document, I acknowledge that I have read and understood the Consent for Care, General Release of Protected Health Information, the financial policies, and all other information stated in this document from Fargo Center for Dermatology. I acknowledge that I have access to a copy of the Notice of the Privacy Practices but declined to accept a copy or took a copy with me. I have had the chance to ask questions, and all my questions were answered to my satisfaction. This consent does not expire until I revoke it, and I understand that I must do so in writing. I know that I have the right to withdraw my consent at any time and that my revocation shall have no effect on any actions taken.

This general consent for treatment and HIPAA release is valid until I revoke in writing.

PATIENT NAME: DATE OF BIRTH:

PATIENT/REPRESENTATIVE SIGNATURE: TODAYS DATE: