DERMATOLOGY ASSOCIATES OF YORK, INC.

CONSENT & AUTHORIZATION

PATIENT: ACCOUNT#:

I am requesting medical services, including but not limited to: evaluation, examination, diagnosis and treatment, from providers at Dermatology Associates of York, Inc. I understand the following:

- Services are provided by physicians, physician assistants, nurses, and other employees of Dermatology Associates of York, Inc. and;

- At times, Dermatology Associates of York, Inc. participates in teaching other medical personnel. A provider may be assisted or accompanied by resident physicians, fellows, or other students engaged in medically related training and education. If I object to the presence of such personnel, I will advise my provider.

I authorize Dermatology Associates of York, Inc. staff to perform diagnostic and/or therapeutic procedures as may be deemed necessary by my attending provider or other authorized health care professional of Dermatology Associates of York, Inc.

I understand that no guarantee or assurance has been made to me as to the results of any care or treatment that is provided. I have been provided the opportunity to ask questions concerning the information contained in this authorization and consent. By signing below, I express my understanding and agreement.

NAME OF AUTHORIZED REPRESENTATIVE: Signature # 1

RELATIONSHIP TO PATIENT:

DERMATOLOGY ASSOCIATES OF YORK, INC.

FINANCIAL AGREEMENT

PATIENT: ACCOUNT#:

I understand that by receiving evaluation, care, and treatment from Dermatology Associates of York, Inc., I am fully responsible for payment of all applicable charges and expenses to the extent they are not fully reimbursed directly to the practice by a third party payor.

I understand that a 24-hour notice to cancel or reschedule an appointment is required. This allows Dermatology Associates the opportunity to provide care to another patient. I understand that a no show appointment fee of $25 for Office Appointments and a $50 fee for Surgical Appointments will be charged for all missed/uncanceled appointments.

I understand that in the event my account becomes delinquent, a processing fee of 30% of the outstanding balance (as calculated on the due date) will be added to my account.

By my signature below, I understand, agree, and accept financial responsibility as set forth in the paragraphs above on behalf of myself or of the patient identified above.

NAME OF AUTHORIZED REPRESENTATIVE: Signature # 2

RELATIONSHIP TO PATIENT:

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for Dermatology Associates of York.

Patient/Personal Representative's Signature: Signature #3 Date:

OR

Personal Representative's Printed Name:

Relationship to Patient:

OFFICE USE ONLY

If The Acknowledgement of Receipt of Notice of Privacy Practices is not signed by the patient, or representative with legal authority to make health care decisions on behalf of the patient, complete the following:

The Notice of Privacy Practices was given to the patient or their personal representative on

The following good faith efforts were made to obtain the signature of the patient, or personal representative:

Reason Patient or Personal Representative did not sign the acknowledgement:

- ☐ Patient/personal representative refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):