



Commonwealth Dermatology, PC

TREATMENT AND PAYMENT POLICIES

Please review and sign the following statement of our Treatment and Payment Policies prior to receiving treatment. For purposes of this document, the terms “you” and “your” shall mean the Patient or the Patient’s Guardian. The patient’s Guardian is a parent or individual who accepts financial responsibility for services rendered to the Patient and is legally authorized to consent and take action on the Patient’s behalf.

Treatment Policy: You understand and consent to the following:

- You have the right to consent, or to refuse consent, to any proposed procedure or therapeutic course of treatment;
- If you are planning to send your child to a subsequent appointment alone or with a non-guardian adult by signing this release, you are allowing Commonwealth Dermatology, P.C. to treat your child and share protected health information with that person. We ask that you confirm your child’s referral and insurance information in advance of each visit;
- Appointment cancellations are required twenty-four hours in advance of scheduled appointments;
- The physicians and/or physician extenders of Commonwealth Dermatology, P.C. and its clinical and technical employees may administer any treatment or perform any procedures deemed advisable during your care and treatment;
- Commonwealth Dermatology, P.C. will provide the best care possible consistent with the prevailing standards of medical practice, but that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury, or even death;
- No assurances or guarantees have been made as to the results of examination or treatment; and
- The Code of Virginia (32.1-45.1) authorizes health care providers to test patients for HIV (Human Immune Deficiency Virus), Hepatitis B virus and Hepatitis C virus when a health care provider is directly exposed to blood or bodily fluids of a patient in a manner which may transmit these viruses. In the event of such exposure, the patient will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who has been exposed.

Payment Policy: You understand and agree to the following:

- By signing this document, you agree to assign to Commonwealth Dermatology, P.C. any and all health care benefits to which you are entitled under any policy of insurance and authorize, to the extent permitted by law, payment of those benefits directly to Commonwealth Dermatology, P.C.;
- You are required to pay, and agree to pay, at the time of service any required co-payment, co-insurance and deductibles, as well as charges for non-covered services; and you will pay all fees and charges for the provided services and are financially responsible for cost of care that your insurance company determines is not covered under your insurance policy and for which you may be held liable under applicable law; non-covered services include services provided in the absence of a referral for patients whose insurance policies require referrals and services provided to patients with insurance in which the practice does not participate, when such insurance involves a limited network; patients are responsible for obtaining their referrals in advance of scheduled appointments;
- Commonwealth Dermatology, P.C. may release, by facsimile or otherwise, any medical or incidental information to any requesting insurance company, federal agency and other physicians as necessary; and
- The information given to Commonwealth Dermatology, P.C. is complete and correct to the best of your knowledge.

I, the undersigned, have read, understand and agree to the policies described above, and understand that Commonwealth Dermatology, P.C. will render medical services in consideration of and reliance on my authority to agree and my agreement to the above terms. I further understand and agree that a photocopy or facsimile of this agreement shall be as valid as the original and that any attempted modification of the above terms shall be void and without effect.

Print Patient’s Name

Patient’s Signature

Date

Witness

Print Guardian’s Name
(If patient is a minor or dependent)

Guardian’s Signature

Date

Witness