Patient Name: _____ **Birth Date:** _____

I understand that the policies below will be valid and remain in effect as long as I receive services from **BOISE DERMATOLOGY**, (hereafter referred to as **BD**); unless revoked by me in writing and written notice provided to **BD**.

(PLEASE INITIAL THAT YOU READ EACH AREA BELOW.)

____ **NOTICE OF PRIVACY PRACTICES:** The law requires that **BD** informs you of your rights related to your personal health information. By signing below, I acknowledge that "protected health information" pertains to my diagnosis and/or treatment including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information. I acknowledge that **BD** may use health information exchange systems to electronically transmit, receive and/or access my medical information.

I acknowledge that the "Notice of Privacy Practices" provides information about how **BD** and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand **BD** cannot be responsible for use or re-disclosure of information by third parties. I acknowledge that I was given the opportunity to read or have explained to me the **BD** "Notice of Privacy Practices" and agree to continue my care with **BD** under said terms.

____ **CONSENT TO TREATMENT:** I voluntarily consent to receive medical and healthcare services provided by **BD**, and its employees, assistants, and other health care providers; as my physician deems necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

____ **AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION:** By signing this form **BD** will only give information to persons indicated below. I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed by **BD**. I understand that information disclosed to the recipient below is no longer protected by federal or state law and may be subject to re-disclosure by the recipient.
Fill out the information below if you wish to have BD release your medical or billing information to family members:

_____ _____ Relationship to Patient: _____
Last Name First Name

Home phone: _____ Cell Phone: _____

____ **FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** I hereby assign to **BD** my right, title, and interest in all insurance, Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct insurance payments to be made, up to the total amount of my health care charges, to **BD**. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for healthcare services not covered by, or which exceed, the amount paid by Medicare, my insurance company, or other third-party payer, and agree to make payment as requested by BD within 30 days of receiving a BD statement that reflects a balance on my account.

___ **PATHOLOGY AND LAB TEST FEES**: I understand that if my visit includes biopsy or lab tests, **I will receive a separate bill from the lab** performing the test. I am responsible for informing BD if my insurance requires use of a certain lab.

____ **NO SHOW AND CANCELLATIONS**: I agree to give more than 24-hour notice for a change to my appointment. If I do not show up for a scheduled appointment or cancel with less than 24-hour notice for three appointments during a 12-month period, **I will be charged $50 for the third no-show**. I may also be required to prepay for my next appointment or be discharged from the practice.

___ **CONSENT FOR CONTACT**: By supplying my phone number or email and other personal contact information, I authorize BD to use a third-party automated system for the purpose of notifying me of a pending appointment, missed appointments, balances due, quality assurance, and any other healthcare related functions.

I hereby acknowledge and consent to the terms set forth in this policy and subsequent changes to the policy.

Patient or Signature: _____ **Date:** _____