HIPAA Notice of Privacy Practices

The law requires that Boise Dermatology informs you of your rights related to your personal health information. By signing below, I acknowledge that I was given the opportunity to read or receive a copy of the Boise Dermatology "Notice of Privacy Practices" .

Signature of Patient/ Responsible party _____Date_____

Release of Medical Information: (optional)

I authorize Boise Dermatology to release my medical and billing information to family member/s listed below.

Name: _____Relation to Patient: _____Contact number_____

Financial Policy and Consent to Treat

- In-office dermatology procedures such as skin biopsy, skin excision, or cryotherapy, may be performed to adequately diagnose or treat your skin condition. Each insurance policy may handle these charges differently and charges may be applied to your deductible, co-insurance or co-pay.
- Pathology and lab test fees are billed separately from the lab performing the test. I am responsible for informing Boise Dermatology if my insurance requires use of a certain lab. If you wish to discuss charges prior to a procedure, please inform our billing staff.
- Full payment is due at the time of service for all co-pays, co-insurance or any deductible amounts. If you cancel your appointment less than 48 hours prior to your appointment time, you will be charged a no-show fee of $25. Boise Dermatology uses third party agencies to collect on accounts that are past due. Returned checks are subject to a $25 fee.

I voluntarily consent to receive medical and health care services provided by Boise Dermatology employees and assistants, as my physician deems necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs and/or other images may be made for medical purposes only. I understand I have the right to refuse any procedure or treatment and that I have the right to discuss all medical treatments with my provider. I authorize Boise Dermatology to use third-party automated system for the purpose of notifying me of pending/missed appointments, balance due, quality assurance and any other health care functions. I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled including private insurance and other health plans to Boise Dermatology. I understand that I am financially responsible for all charges that are not paid by insurance including all diagnostic testing. I hereby authorize Boise Dermatology to appeal any incorrect insurance payment. I release Boise Dermatology from all legal responsibility or liability that may arise from this authorization. I understand that this Consent to Treatment/Health Care Agreement will remain in effect as long as I receive services from Boise Dermatology unless revoked by me in writing.

Patient name: _____ DOB_____

Signature of patient/Responsible party_____

Relation to Patient_____