RSC ROSWELL SKIN CENTER

Consent for Treatment and Acknowledgement of Privacy & Financial Practices

I authorize Roswell Skin Center and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I acknowledge that I have had the opportunity to review Roswell Skin Center's Notice of Privacy Practices, which is available for public inspection at its facility and on its website. I understand that I can request a paper copy at any time. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Roswell Skin Center to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring health care provider, primary care provider, and any healthcare provider(s) I may be referred to. I also authorize Roswell Skin Center to release any information required for obtaining prior authorizations, for the processing of any billing and insurance claims, and for other health care operations.

I give my consent for Roswell Skin Center to retrieve and review my medication history electronically as part of an electronic prescription system. I understand that this will become part of my medical record. I further understand that my prescriptions will be sent to the pharmacy electronically and give consent for this method.

I consent to engaging in virtual health or telemedicine services, where available and appropriate, as part of my treatment. I understand these services may include diagnosis, treatment, consultation, transfer of medical data and education using interactive audio, video or data communications. The systems used for these services will include security safeguards to protect confidentiality of patient information.

I consent to the photographing or videotaping including appropriate portions of my body for medical and documentation purposes. I understand such photos and videos will be part of my medical record and will be maintained and released in accordance with protected health information regulations.

I authorize Roswell Skin Center to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Roswell Skin Center. I authorize Roswell Skin Center to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers which is needed to substantiate claim and payment.

_____ **I understand that payment in full is expected within 30 days of being notified of any balance due. I understand that I am personally responsible for all charges not covered by the assignment of insurance benefits. For all cosmetic or self-pay services, payment in full is expected at the time of service. I acknowledge that I have had the opportunity to review Roswell Skin Center's Financial Policy, which is available for public inspection at its facility and on its website.**

_____ **I understand that if I no-show an appointment or do not give advance notice of cancelation, I may be assessed a $25 no-show fee (or $100 for missed cosmetic visits or other procedures), solely at the discretion of Roswell Skin Center. If assessed, I understand this fee must be paid in full before I will be rescheduled.**

_____ **I understand that any dispute arising from this contractual relationship or from the medical or cosmetic care and treatment provided by any person(s) employed or contracted to care for me by Roswell Skin Center in Roswell, New Mexico shall be governed by the laws of the State of New Mexico and shall be decided solely and exclusively in Chaves County, NM, regardless of who makes such a claim. I further understand that this agreement will be binding and inure to the benefit of Roswell Skin Center and the patient and their respective heirs, personal representatives, successors, and assignees.**

If any provision(s) of this Agreement are deemed to be unenforceable, all other provisions will remain in full force and effect as if the invalid provision had not been part of this Agreement. Roswell Skin Center reserves the right to unilaterally modify this Agreement to conform to laws and regulations as may be passed from time to time. Reasonable notice, considering all of the circumstances, will be given to patients when any change is made in accordance with this paragraph. No provision of this Agreement will be deemed to have been waived by Roswell Skin Center or by any of its owners, contractors, and employees unless done in writing and signed by an authorized representative of Roswell Skin Center.

Authorization to Disclose Protected Health Information

Please print the name and relationship for each person to whom you are authorizing release of your private health care information and account balances. Each person you wish to be considered MUST be listed individually by name *(ie. Spouse/significant other, parent, friend, or family member*). **IF YOU DO NOT LIST ANYONE, WE WILL ONLY SPEAK TO YOU.**

Party:_____ Relationship:_____

Party:_____ Relationship:_____

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV- related diseases and communicable disease-related information.

With respect to any drug abuse or communicable disease-related information protected by State and Federal confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I hereby acknowledge that I have read this page and all preceding pages and acknowledge that this agreement represents the entire agreement between me and Roswell Skin Center.

Signed:_____ Date: _____

Printed Name: _____

Representative of Roswell Skin Center:_____ Date:_____