ARLINGTON CENTER FOR DERMATOLOGY
"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

Angela Yen Moore, M.D.
Board Certified Dermatologist by the American Board of Dermatology
Board Certified Dermatopathologist by the American Board of Medical Specialties
711 E. Lamar Blvd. Suite 200 • Arlington, Texas 76011
817/795-SKIN (7546) • fax: 817-385-7568 • email: acderm@acderm.com

ASSIGNMENT OF INSURANCE BENEFITS, IMAGE RIGHTS, AND MEDICAL INFORMATION RELEASE AUTHORIZATION

Insurance Benefits: I authorize the release of information necessary to process any claim. I certify the information I supply is true and correct to the best of my knowledge. I authorize payment of medical benefits to be made on my behalf to Arlington Center for Dermatology (ACD). I authorize photocopies of this form to be valid as the original.

Consent to treat: I authorize medical procedures to be performed on the patient named below at the direction of the physicians(s) of Arlington Center for Dermatology.

Image Rights: I authorize the use of any and all medical photography taken of me during medical, research or cosmetic treatments by Arlington Center for Dermatology for educational, research, scientific purposes. Such images may be edited, copied, broadcast, published or distributed by ACD. I waive any right to review, approve, or gain compensation or royalties for the use of these medical images by ACD. I understand that any and all use of these medical images will be done while protecting and concealing any and all identification data so that my personal identity will be duly protected and never revealed to the public.

RELEASE OF MEDICAL INFORMATION

I authorize Arlington Center for Dermatology to release medical information (including chart notes, lab results, pathology results) to my primary care physician and/or specific healthcare providers requesting such information in regards to my healthcare.

I also authorize my physician to release confidential medical information, on my behalf to my insurance carriers and their employees in order to evaluate my insurance, reimbursement, and coverage for office visits and treatment and also may contact my employer and/or medical provider(s), to complete my request for payment.

I assert that I am a legal adult of 18 years of age or older and that if I am signing for a minor I am a legal guardian of the identified minor. I authorize Arlington Center for Dermatology to release medical information over the telephone to the following:

_____ Myself only

_____ Information may be left on patient's voice mail at this number

Patients Phone # (_____)_____

_____Listed persons who we can speak to about your records:

List Names: _____

Signature on file:
I acknowledge that I have read and agree to be bound by the terms and office policies stated above in areas of the Assignment of Insurance Benefits and Medical Information Release Authorization. The duration of this authorization is indefinite or until it is revoked in writing.

PATIENT NAME: _____ **DATE:** _____

Signature: _____
(Patient or legal representative)

ARLINGTON CENTER FOR DERMATOLOGY
"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

Angela Yen Moore, M.D.
Board Certified Dermatologist by the American Board of Dermatology
Board Certified Dermatopathologist by the American Board of Medical Specialties
711 E. Lamar Blvd. Suite 200 • Arlington, Texas 76011
817/795-SKIN (7546) • fax: 817-385-7568 • email: acderm@acderm.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the ARLINGTON CENTER FOR DERMATOLOGY (ACD) Notice of Privacy Practices ("Notice"):

- It tells me how ACD will use my health information for the purposes of my treatment, payment for my treatment, and ACD's health care operations.
- The Notice explains in more detail how ACD may use and share my health information for other than treatment, payment, and health care operations.
- ACD will also use and share my health information as required/permitted by law.
- As an ACD PATIENT receiving ACD health services, I consent to ACD using and disclosing my treatment records
  maintained by ACD for the purposes detailed in ACD's Notice of Privacy Practices.

Patient's Complete Legal Name: _____
(Please print)

Patient's DOB: _____

Signature: _____
(Patient or legal representative*)

Date: _____

* May be requested to show proof of representative status

ARLINGTON CENTER FOR DERMATOLOGY
"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

Angela Yen Moore, M.D.
Board Certified Dermatologist by the American Board of Dermatology
Board Certified Dermatopathologist by the American Board of Medical Specialties
711 E. Lamar Blvd. Suite 200 • Arlington, Texas 76011
817/795-SKIN (7546) • fax: 817-385-7568 • email: acderm@acderm.com

PATIENT FINANCIAL POLICY

We are committed to providing you and your family the best possible care. In order to achieve this, we need your assistance as we explain our payment policy. Please read over the details of this form carefully.
We will be happy to file your insurance for you. In order to file insurance, you must:

- Provide our office with a current insurance ID card. We must make a copy of this card for our files.
- If your insurance requires a referral, it is your responsibility to get a referral from your PCP (primary care physician), to our office, prior to your appointment. Be aware, it is always your responsibility to get new referrals as needed throughout your treatment. Failure to obtain valid and current referrals may result in insurance charges being charged to the patient.
- Co-pays are due at the time of service. Be aware that you are responsible for meeting all deductibles and/or co-insurance amounts required by your policy.
- If your insurance requires us to send your biopsy to an outside designated lab, the estimated charges given to you do not include the path charges. You will be billed separately from the appropriate lab.

It is your responsibility to inform us of any changes in your insurance coverage or employment. Please verify, with your insurance company that Dr. Moore is an "in network provider" for your insurance. Your insurance is a contract between you, your employer, and your insurance company.
We will file Medicare and a secondary or supplemental policy. You will receive a bill for any amount approved by Medicare but not paid by your secondary plan.
If you do not have your insurance card or if insurance cannot be verified before you check out, you are required to sign a waiver stating you understand that you, personally, are responsible for the balance at the time services are rendered.
In order to be treated at Arlington Center for Dermatology, you must:

- Present your driver's license (or photo ID if not a licensed driver). We must make a copy of this for our files. This confirms your identity and protects your privacy.

Payment for cosmetic products and /or procedures is required in full at the time services are rendered.

Please Note:

- Be aware that treatment using liquid nitrogen (often called "freezing" or "LN2") is considered a **surgical procedure** by insurance, and must be billed as a surgery. Also some injections are considered surgical as well and you could be billed for these. If your policy has a surgical deductible, all "freezing" procedures and/or injections will be billed as a surgery and you are responsible for meeting that deductible.
- LN2 treatment may require more than one visit for effectiveness of treatment. Second, third and follow-up treatments of the same lesions with LN2 may be required by the provider. All follow-up treatments of LN2 will be charged to the patient and/or to his or her insurance.
- Any Patch Testing requires co-pay for each visit of the test, which is usually three (3) visits. Please confirm with your insurance company that patch tests will be paid for by your insurance contract. Not all insurance companies will pay for patch testing.
- In accordance with Federal Law and per the stipulations of your Insurance contact, whenever you are seen by a medical provider, you will be responsible for making a copayment. You must pay this co-payment on the same day you see the provider.

We realize that temporary financial problems may affect timely payment of your account. If problems do arise please contact us promptly for assistance in managing the account.
Also be aware that if your insurance has not paid within 60 days, the full amount becomes your responsibility. We accept cash, checks, Visa, and MasterCard.

I have read and understand this financial policy and agree to abide by the terms and expectations listed above.

PATIENT NAME: _____ **DATE:** _____

Signature:
(Patient or legal representative) _____