MIDWEST CENTER FOR DERMATOLOGY & PATHOLOGY, PLLC

Responsibility of Payment / Community Resources / Release of Information / Appointments Privacy Policy
Clinical Trial Volunteer / Personal Representative / Advanced Care Plan / Teaching Facility

DATE: ____________________________

Name:____ DOB:____/____ /____ Gender: _____ Age: _____
Last First MI

☐ Home:___________________________ ☐ Work:__________________________ ☐ Cell:_______________________

☐E-Mail:____

May we leave a message at: ☐ Home ☐ Work ☐ Cell

Referred by: ____

If patient is a child: Father's Name: ___________________________ Mother's Name:___________________________

Guardian's Name: _______________________________

Insured's Name: ____ Insured's DOB: _____/______/______

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Primary Insurance: _______________________ Policy Number: _________________ Policy Group: _________________

Secondary Insurance: _______________________ Policy Number: ________________ Policy Group: ________________

Primary Care Physician: _____________________________________ Telephone:_________________________________

In case of emergency who should we contact: _______________________________Contact#: ______________________

RESPONSIBILITY OF PAYMENT/RELEASE OF INFORMATION

- The information that I have provided to MCD is complete and accurate.
- I authorize the physicians in charge of medical care to administer treatment, release to the Social Security Administration, its intermediaries, or other insurance carriers any information related to this treatment for the purpose of obtaining insurance benefits. I permit a copy of this authorization to be used in place of an original. Benefits shall be assigned exclusively to my provider at MCD / 26-1250512.
- I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.
- I understand payment is required for all services at the time they are rendered unless I am in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected.
- I understand that you accept payment in the form of check, cash, or major credit card except for cosmetic procedures which may be paid only by cash or credit card.
- I understand, in the event of major procedures, our office may file the appropriate insurance claims. However, before such claims are filed, coverage will be pre-verified and I will be asked to pay any unmet deductible, non-covered services and co-payments.
- I understand that any balances or services not covered after billing my insurance carrier will be my responsibility.
- I understand, in the event that my account must be turned over to a Collection Agency, that I will be responsible for all collection fees.
- I agree, in order for MCD to service my account or to collect any amounts I may owe, MCD and its third party billing and/or debt collection services providers may contact me by telephone or at any telephone number associated with my account, including wireless telephone numbers. Standard message and data rates apply.

PCMH (Patient Centered Medical Home) – COMMUNITY RESOURCES

I do ☐ / **I do not** ☐ have a need for community resources.
If yes, please tell us how we can assist you ____

CONFIRMATION OF APPOINTMENTS – PHONE / TEXT MESSAGES / E-MAILS
I authorize contact via phone, text messages or e-mail, using the e-mail address I provide, for the confirmation of appointments. Methods of contact may include using pre-recorded /artificial voice messages and /or use of automatic dialing service, text messages and/or e-mails. Text messages may result in charges depending on my service provider.

☐ **Accept** ☐ **Decline**

NOTICE OF PRIVACY POLICY
I acknowledge that I have read &/or received a copy of the Midwest Center for Dermatology & Pathology, PLLC – Clinton / Warren / Farmington Hills / Shelby and St. Clair Shores, Notice of Patient Privacy: Version September 23, 2013.

CLINICAL TRIAL VOLUNTEER
I authorize MCD in conjunction with Michigan Center for Skin Care Research located within our facility, to contact me regarding voluntary participation in any clinical research studies which may benefit my medical condition. Authorization is for information only and does not obligate participation or affect my treatment. All information will be sent directly from this office, MCD, or from the Michigan Center for Skin Care Research and not from a Third Party. Information will be received via newsletters, personal letters, flyers, e-mail blasts, text messaging or other digital avenues.

☐ **Accept** ☐ **Decline**

DELEGATION OF PERSONAL REPRESENTATIVE
I hereby nominate the following person to act as my personal representative with respect to decisions involving the use/disclosure of health information as it pertains to me. This person is to be afforded all of the privileges that would be afforded me with respect to my health information. I understand that I may revoke this designation at any time by signing a revocation notice. I further understand that this revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this information.

Name of Personal Representative:____

ADVANCE CARE PLAN – FOR AGE 65 AND OLDER ☐ **Not Applicable**

I do ☐ / **I do not** ☐ have an advanced care plan. Definition: A legal document expressing a person's wishes about critical care when he/she is unable to decide for himself/herself**.**

If yes: Name______________________________ Relationship____________________ Contact #________________

PRESCRIPTION HISTORY
Midwest Center for Dermatology & Cosmetic Surgery has permission to obtain my prescription history electronically.

☐ **Accept** ☐ **Decline**

TEACHING FACILITY
MCD is a teaching facility where residents may work with the attending physician at your discretion.

I HAVE READ THIS CONSENT FOR RESPONSIBILITY OF PAYMENT/RELEASE OF INFORMATION, PCMH, CONFIRMATION OF APPOINTMENTS, NOTICE OF PRIVACY, CLINICAL TRIAL VOLUNTEER, DELEGATION OF PERSONAL REPRESENTATIVE, ADVANCE CARE PLAN AND TEACHING FACILITY. I ACCEPT THE ABOVE STATED TERMS AS I HAVE INDICATED ABOVE.

Patient / Responsible Party Signature_____________________________________ **Date**____________________

Relationship Responsible Party____