

Acknowledgment of Conditions for Treatment & Financial Disclosures:

CONSENT FOR CARE: I agree to care and treatment that may include examinations, tests, labs, anesthesia, and medical or surgical treatments provided by licensed providers at Puyallup Dermatology. Treatment in our office may include pathology/lab charges performed by our doctors and/or independent laboratories. These are tests that need to be done in order to determine or confirm a diagnosis. Charges for these services can come directly from the independent laboratory or from our office. Certain treatments/procedures including liquid nitrogen (freezing) and biopsies are considered "surgical" and will be processed separately from an office visit by your insurance company. PRIOR to the start of the service/test, please ensure you have verified if your service/test is a covered benefit by your insurance plan. Additional documents and consent forms may be required for specific procedures. Care may be delivered via secured audio video platforms or secure, asynchronous internet-enabled platforms if you are scheduled for a virtual appointment. I understand I have the right to ask questions about my care at any time, and to be involved in my care decisions.

RISKS OF TREATMENT: NO GUARANTEE OF RESULTS OR CURE: No promise or guarantee of results or cure has been made to me by Puyallup Dermatology staff and/or providers. I know there are risks related to surgical, medical, or diagnostic procedure(s). These risks may include, but are not limited to;

- Permanent scars of treated area
- Pain, stinging, swelling, bruising, redness and skin discoloration of treated area
- Incomplete removal which may require an additional procedure.
- Recurrence.
- Infection, bleeding, bruising, or nerve damage of treated area.
- Allergic reactions to anesthesia, antibiotic creams, tape, antiseptic soaps, or oral antibiotics.

PHOTOGRAPHS FOR TREATMENT, DIAGNOSIS AND/OR IDENTIFICATION: For diagnosis and treatment purposes, I allow images such as photographs to be taken and used. These images may be used to add to written information about my illness or condition. Some images are used once and immediately discarded when no longer needed. Others may be kept as part of my medical record, at the option of my treatment providers. Photographs of me may also be taken for identification purposes. Any photograph taken by Puyallup Dermatology staff, goes directly into EMR system and not used outside of diagnosis, treatment, and identification purposes.

FINANCIAL AGREEMENT: I agree to pay Puyallup Dermatology Clinic for care at its regular rates and terms applicable to my care and any applicable health insurance coverage I have. If I do not have health insurance, I agree to pay for all services rendered at the time of service. I permit Puyallup Dermatology Clinic to appeal any denial received from my insurance company. If a third-party payor will not pay, I agree to pay for the services given, subject to any applicable contractual or governmental regulations. If a third party caused my injuries, I understand that Puyallup Dermatology Clinic does not participate in LNI billing and I will pay up front for all services rendered. If my bill is sent to a lawyer or collection agency, I will pay all reasonable attorneys' fees and costs, together with interest and any amounts otherwise found to be owing. Information about the estimated charges for health services is available upon request. I understand I have the right to request this information. If my insurance requires me to pay a copay, I agree to pay at the time of service. Per insurance company contractual requirements, we will collect your co-pay at each appointment you see a provider. Puyallup Dermatology offers a 20% discount to patients with no health insurance. This discount is applied at each appointment. I understand that I may not be able to schedule appointments with Puyallup Dermatology if I have an unpaid account balance.

Insurance Cards: Insurance companies require their contracted patients to present a current insurance card at the time of service. Per insurance company contractual requirements, we will take a copy of your insurance card at each

appointment. If you cannot present a current insurance card, you will be required to pay in full prior to being seen if we are unable to verify your insurance plan.

MEDICARE: Puyallup Dermatology Clinic insurance and patient billing processes are consistent with the requirements established by CMS. If I am a Medicare participant, I understand that I need to pay for services that are not covered by the Medicare Program. This may include, but is not limited to, cosmetic surgery, take-home and "over the counter" medications, services not medically needed, personal items, services covered by car or liability insurance, or where a third party is otherwise responsible for any accident or injury leading to my need for care, as well as any services not otherwise covered by Medicare

ASSIGNMENT OF BENEFITS; PERMISSION TO ALLOW PUYALLUP DERMATOLOGY TO DETERMINE AND OBTAIN BENEFIT INFORMATION AND PAYMENT: I permit payment from insurance or other third-party payors to go to Puyallup Dermatology Clinic directly. I permit Puyallup Dermatology staff, to determine and obtain benefit information, and get paid from all available payor sources.

PHONE, EMAIL, TEXT MESSAGING AUTHORIZATIONS: I grant permission and consent to Puyallup Dermatology to contact me using any email addresses or phone numbers associated with me, including wireless (cell) numbers, for any purpose related to my care, including the availability of services at Puyallup Dermatology. I also represent that I am the owner or a customary user of the phone number(s) provided and have authority to grant the permission and consent to contact described herein. This consent and permission includes (1) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (2) to send me text messages or emails using any email addresses or cellular device numbers; (3) to send me paperless billing by email or text notifications; (4) to use pre-recorded/artificial voice messages and (5) use of an automatic dialing device (an "auto dialer") in connection with any of these communications. I understand that I am not required to accept messages in these formats as a condition of receiving services at Puyallup Dermatology. I understand that I have the option to "opt out" of receiving such emails or text messages, which I may exercise at any time by following the opt out option contained in the message, or notifying Puyallup Dermatology staff to discontinue such communications using those pathways. Unless I have opted out, communications may continue after the expiration of this consent form.

Automobile accident cases: Puyallup Dermatology Clinic does not bill motor vehicle insurance. There is a minimum appointment charge of \$293.70 which must be paid prior to being seen for your appointment. In some cases, the charge will be more, depending on the level of service provided, but all motor vehicle-related charges must be paid at the time of service.

Divorce and child custody cases: Puyallup Dermatology Clinic does not get involved in divorce or child custody issues. As with all other accounts, payment must be made at the time of service and only insurance that has been verified will be billed. The parent accompanying a child is responsible for payment. The adult receiving services is responsible for their own charges outside of insurance.

By signing this consent, I understand and agree with statements listed above.

This consent will remain valid for one year from the date of signature.

Dated this _____ day of _____, 20____.

Patient Name: _____

Patient Signature: _____

Name of Parent or Legal Guardian if signing: _____

Signature of Parent or Legal Guardian if signing: _____