CONDITIONS OF TREATMENT

Medicare

Thank you for choosing us at Alaska Center for Dermatology (“Practice,” “us,” “we,” “our”) as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your health. This Conditions of Treatment document outlines several of our policies that impact you, as well as certifications and consents that you provide to us to enable us to use your information for various purposes that are part of our relationship with you. Therefore, if you have any questions or concerns about any of the policies, certifications, or consents contained below, please do not hesitate to ask our staff.

1. **FINANCIAL POLICY:**
   - Insurance coverage is not a guarantee of payment.
   - You will receive a statement for any allowed balance after all applicable insurance have been billed. The balance is due in full at that time.
   - In the event your insurance company does not pay the claim within a reasonable amount of time (45 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
   - If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit in full becomes your responsibility.
   - It is the policy of this office that the adult presenting a child/minor for treatment is responsible for payment.
   - Cosmetic procedures will not be billed to insurance and the cost of the procedure will be due at time of service. Your provider will determine if procedures are cosmetic or medically necessary.

2. **FINANCIAL AGREEMENT: The undersigned in consideration of the services to be rendered to the patient is obligated to pay the Practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney’s fees and collection expenses. The undersigned hereby assigns to the medical Practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the Practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.**

3. **PATIENT’S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

4. **CONSENT TO EMAIL, CALLS AND TEXT COMMUNICATIONS:** These messages will not include Protected Health Information (PHI) or clinical information. If at any time you provide an email address or residential or wireless/mobile telephone number to the Practice, **you give your prior written consent to receive emails, calls and text messages for service-related communications to such email address(es) and phone number(s).** Emails, voicemails and text messages have inherent privacy risks, especially when access to your computer or mobile device is not password protected, is shared by others, or access is provided by your employer or public facility. Further, consenting to receive emails, calls, and/or text messages from the Practice, you understand and acknowledge that communications transmitted via unencrypted email or via text messages over an open network are unsecure, and could be accessed by an unauthorized third party in transit. Please do not send any information that is considered especially sensitive through these communication channels (e.g., medical diagnosis information, personal health history), as it may be received or accessed by unintended recipients, intercepted, altered or used without authorization or detection.

You may notify the Practice if you wish to opt out of certain email messages, phone calls and text messages. Please understand that you may continue to receive services communications via email, however, in order for us to fulfill a request or communicate with you about your account. In addition, we may still respond to any communications you initiate and send to us, including via phone or text, in order to respond to your request or question even if you have previously told us that you do not wish to be contacted using those communication methods.

- Message and data rates may apply.
- Please also note that messages are unencrypted, and unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties, and/or stored or archived by service providers and system operators.
- You certify that you are the user and/or subscriber of any email address and telephone number you provide to Practice and accept responsibility for email, call and text communications sent to or from this address or number. You agree to notify Practice in writing in the event your email address or telephone number changes.

  Service-Related Communications: Service-related communications that you consent to receive include but are not restricted to communications regarding billing and payment for products and services, appointment reminders, and other healthcare communications and communications about your condition(s), care, treatment, referrals or appointment(s).

By signing below, you certify that you are the user and/or subscriber of the email address and/or mobile number previously provided, and accept full responsibility for emails and/or text messages sent to or from this address or number. You agree to notify the Practice in writing in the event your email address or mobile number changes.

There may be a delay when responding to messages; thus, if you have an urgent situation, you should not rely on messages sent to the Practice to request assistance, but instead should seek assistance by means consistent with your needs (e.g., by contacting your provider/care team directly or calling 911).

To the extent permitted by law, you hereby agree to hold the Practice and its affiliates harmless from any and all claims and liabilities arising from or related to emails or text messages sent to the email address and/or number previously provided.

I have read and fully understand the above Conditions of Treatment and have been given the opportunity to ask questions.

Signature of patient (or legal guardian) Date

Email address:____ Telephone:

If other than patient:

_______________________________ ____

Relationship of Representative Reason individual is unable to sign (i.e. minor or legally incompetent etc).

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