Glenn H. Brown, M.D., PLLC
Dermatology and Dermatological Surgery

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Glenn H. Brown, M.D., Dermatology, may use and disclose **protected health information (PHI)** about me to carry out **treatment, payment, and healthcare operations (TPO)**. Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.

- I have the right to request that Glenn H. Brown, M.D., Dermatology, restricts how it uses or discloses my **PHI** to carry out **TPO**. The practice is not required to agree to my requested restrictions, however; if it does, it is bound by this agreement. By signing this form I am consenting to Glenn H. Brown, M.D., Dermatology, the use and disclosure of my **PHI** to carry out **TPO**.
- I may revoke my consent in writing except to the extent that the practice has already made discussions in reliance upon my prior consent. If I do not sign this consent, Glenn H. Brown, M.D., Dermatology, may decline to provide treatment to me.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Glenn H. Brown, M.D., Dermatology, reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Glenn H. Brown, M.D. Dermatology.

I give consent to Glenn H. Brown, M.D. Dermatology, or a designated staff member, to call my primary or secondary designated phone number to speak to me and/or leave a voice message, and/or fax a designated number in reference to any medical information that assists this Practice in carrying out TPO, such as appointment reminders, insurance information, patient statements, calls regarding labs and pathology results, or other clinical care as it relates to you.

If you wish to consent to this, please initial here: _____ If you DO NOT wish to consent to this, please initial here: _____

Financial Policy: Payment in full is required at the time services are rendered unless you are currently enrolled and eligible under one of the insurance plans that list Glenn H. Brown, M.D. as an in network provider. Please check with your insurance company to verify this information as it varies by carrier and policy. Please understand health plans have different co-pays, deductibles, and rules regarding allowed visits for certain covered services. This may or may not be defined by your individual policy and/or employer group. If our office participates with your health plan, we will honor their fee schedule and discounts, and you will be responsible for your co-payments and/or deductible (both may apply). If our office does not participate with your health plan, payment in full is due at the time of service. We accept the following methods of payment: Cash, Check, Money Order, Debit Cards, Discover, MasterCard and VISA. There will be a $30.00 processing fee for all returned checks.

Patient Statements: When a claim is submitted to your insurance company and payment is received, a statement will be sent to you. Our billing company will send 3 statements to you. If an account remains open after 90 days, your account will be turned over to a third party collection agency with an additional collection fee.

Missed Appointments: As a courtesy to our patients, an automated reminder call/text message will be given 24-48 hours in advance. If you are unable to keep your appointment, a 24 hour notice is required. If you provide us with less than a 24 hour notice, or you No Show for your appointment, a "Missed Appointment" fee will be charged to your account in the amount of $30.00. Cosmetic and Surgery appointments will be charged a "Missed Appointment" fee of $100.00. This amount must be paid prior to any future visits with our office.

Referral Forms for HMO Plans: If your insurance requires a written referral for your visit, you must request this from your primary care provider. We accept faxed referrals from your primary care provider, however; we do not make contact with your physician to have referrals sent to us on your behalf. It is the responsibility of the patient to be prepared for their visit at the time they are seen. If we do not have a referral 24 hours before your appointment, you may reschedule your appointment or sign a waiver of benefits for that visit and make payment in full that day.

I authorize the release of medical information to my primary care, referring physician, consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

I have read and understand the above administrative and financial policies of Glenn H. Brown, M.D., PLLC.

Print Name of Patient or Legal Guardian: _____ Today's Date: _____/_____/_____

Patient or Legal Guardian Signature: _____