PITTSBURGHSKIN
DERMATOLOGY | MOHS SURGERY

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Medical Director

INTAKE FORM - Consent for Treatment

Date: _____

Patient Name: _____ DOB: _____

Pittsburgh Skin Statement of Patient Financial Responsibility

Pittsburgh Skin appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Pittsburgh Skin for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pittsburgh Skin, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient consent for use and disclosure of protected health information

With my consent, Pittsburgh Skin, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. Please refer to Pittsburgh Skin's Notice of Privacy Practices for a more complete description of such uses and disclosures. Pittsburgh Skin reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained at Pittsburgh Skin, 144 Emeryville Drive Suite 230 Cranberry Township, PA 16066.

Consent for Treatment and Authorization to Release and Receive Information

I hereby authorize Pittsburgh Skin, through its appropriate personnel to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.
I further authorize Pittsburgh Skin, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.
I authorize Pittsburgh Skin to send and receive information with my pharmacy, including my prescription fill history. This information is used to ensure we have an up to date medication history and to prevent medication interactions.

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. **If you no show for an appointment without 24-hour notice, you will be charged a 25$ fee for a general dermatology appointment and 50$ for a procedural dermatology appointment.** If you no show for two consecutive appointments or no show for a total of three appointments, you may be discharged from care.

Patient Portal

You can now access your medical information using our patient portal: update your chart, receive test results, and send us messages. By providing us with your email address, you are giving us consent to activate your online portal.

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Communication of records/results
With my consent, Pittsburgh Skin may leave a message with results and/or recommendations at this number:

Name:_____ Phone number:_____

☐ ok to leave message at this number

With my consent, Pittsburgh Skin may share health information, results and treatment recommendations with the following people:

Name:_____ Phone number:_____

Relationship to patient: _____

Name:_____ Phone number:_____

Relationship to patient: _____

Acceptance of the Above Policies
By signing below, I am consenting to the statement of financial responsibility, consent for treatment and authorization to release information, cancellation/no show policy, and indicating my preference on patient portal use.

Patient/Guarantor Signature_____ Date:_____