

**Dermatology & Plastic Surgery Associates, S.C.**

1124 Essington Road

Joliet, IL 60431

**Consent to Treatment**

I voluntarily consent to receive medical care services that may include diagnostic procedures, examinations, and treatments.

**\*\*Please complete the signature page to acknowledge receipt and understanding of this document.**

**Financial Responsibility and Assignment of Benefits**

I agree to pay all charges for medical and health care services not covered by my insurance company.

**\*\*Please complete the signature page to acknowledge receipt and understanding of this document.**

**Dermatology & Plastic Surgery Associates, S.C.**  
**Paula K. Lapinski, M.D. and Jose L. Rios, M.D.**  
**1124 Essington Road, Joliet, IL 60431**

**GENERAL PATIENT AUTHORIZATION**

I hereby authorize physicians of Dermatology & Plastic Surgery Associates, S.C. to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

In consideration of services rendered or to be rendered, I assign and transfer to Dermatology & Plastic Surgery Associates, S.C. any benefits payable to me or on my behalf under any insurance coverage. I agree to fulfill all policy provisions which my insurance companies may require for payment. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I further agree to pay for any items or services not covered by the Medicare Program. I hereby understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract.

I understand that I am responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dermatology & Plastic Surgery Associates, S.C.. I further understand, should this account become delinquent, I shall pay the reasonable attorney or collections expenses.

I understand that if I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services.

I authorize Dermatology & Plastic Surgery Associates, S.C. to release medical information pertaining to my diagnosis and/or treatment, laboratory test results, medical history, treatment, or any other such related information to:

1. Medicare or Medicaid
2. My insurance company or its designated representatives
3. Any person(s) or entities financially responsible for my care or treatment
4. Representatives of local, state, or federal agencies in accordance with law
5. Employees or representatives of Dermatology & Plastic Surgery Associates, S.C. for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Dermatology & Plastic Surgery Associates, S.C. or the employees of Dermatology & Plastic Surgery Associates, S.C.

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**MEDIGAP RELEASE**

For Medicare patients with supplemental Medigap insurance, a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize to be released to my Medigap carrier any information needed to determine benefits.

**\*\*Please complete the signature page to acknowledge receipt and understanding of this document.**

**\*\*\*Please provide us with your driver's license and insurance cards.**

**Dermatology & Plastic Surgery Associates, S.C.**

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**Patient HIPAA Authorization Form**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or dis/closed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- \* Protected health information may be disclosed or used for treatment, payment, or health care operations
- \* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- \* The Practice reserves the right to change the Notice of Privacy Practices
- \* The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- \* The patient may revoke this Authorization, in writing, at any time and all future disclosures will then cease
- \*The Practice may condition receipt of treatment upon the execution of this Authorization

**\*\*Please complete the signature page to acknowledge receipt and understanding of this document.**

**Practice Policies**

In order to serve your needs better, we ask that you read our policies and sign below.

1. We request a 24 hour cancellation notice. Failure to call, no shows, will be charged a \$25 administrative fee that is not billable to insurance. Surgery no shows will be charged \$75.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy for refill requests.
3. If a patient loses their lab requisition form, there is a \$5 administrative fee for a replacement
4. Copays and deductibles are due at the time services are rendered.
5. Patients are responsible for verifying insurance coverage.
6. We attempt to make courtesy phone calls to remind you of an appointment, but are unable to provide this service at all times. Lack of a reminder phone call does not cancel the above no show policy.
7. All returned checks will be charged a \$25 administrative fee

**\*\*Please complete the signature page to acknowledge receipt and understanding of this document.**

**Dermatology & Plastic Surgery Associates, S.C.**

**Signature Page**

\_\_\_\_\_ I have read and understand the **“General Patient Authorization”** provided  
(initial) to me by Dermatology & Plastic Surgery Associates, S.C.

\_\_\_\_\_ I have read and understand the **“Medigap Release”** provided to me by  
(initial) Dermatology & Plastic Surgery Associates, S.C.

\_\_\_\_\_ I have completed, and understand the terms of the **Telephone Information  
& Communication Release”** provided to me by Dermatology & Plastic  
(initial) Surgery Associates, S.C.

\_\_\_\_\_ I have read and understand the **“Patient HIPAA Authorization Form”**  
(initial) provided to me by Dermatology & Plastic Surgery Associates, S.C.

\_\_\_\_\_ I have read and understand the **“Practice Policies”** provided to me by  
(initial) Dermatology & Plastic Surgery Associates, S.C.

\_\_\_\_\_ I have read and understand the **“Consent to Treatment”** and the  
(initial) **“Financial Responsibility and Assignment of Benefits”** policies as  
provided to me by Dermatology & Plastic Surgery Associates, S.C.

I, \_\_\_\_\_, acknowledge that the above initials are my own, and that they represent my understanding of each of the aforementioned documents (**“General Patient Authorization”, “Medigap Release”, “Telephone Information & Communication Release”, “Patient HIPAA Authorization Form”, Practice Policies”, “Consent to Treatment”, “Financial Responsibility and Assignment of Benefits”**).

I understand that a copy of any of the aforementioned documents can be provided to me upon request.

**Electronic & scanned signatures shall be accepted by all parties as original signatures.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date