Patient Consent Form

Lifetime Skin Care Centers Financial Policy

Contracted Insurance

Our office is contracted with most insurance plans. If you are unsure if we are in network, please ask.

Contracted insurance will be filed at time of service for all procedures. We require that deductibles and office visit co-payments be paid at time of service.

Non-Contracted Insurance

Our office is not contracted with Medicaid or other state funded plans (HIP, Hoosier Healthwise, Managed Health services). All other non-contracted insurances will be filed with as a courtesy to our patients. We will expect payment for all office visits at the time of service. If any additional procedure is performed, we will expect payment for the office visit **AND** 20% of the procedural charge(s).

Co-pays/Co-insurance/Deductibles

Co-payments are due at the time of service. When policy deductible has not been met for the year, we will collect your policy coinsurance amount or 20% of all procedures performed at the time of service. Patients with multiple insurance policies will be billed for any balances after insurance processes.

Cosmetic/Esthetic Services

All cosmetic services are payable in full at the time of service with cash or credit card. **We do not accept personal checks as payment on cosmetic services or gift card purchases**. There are no discounts on cosmetic services unless otherwise indicated.

Good Faith Estimates

You have a right to request a good faith estimate of the total price that will be charged for any non-emergency service that has been ordered, scheduled, or referred. ***Please be aware that if you are receiving diagnostic services, additional testing and/or outside laboratories may be utilized as a necessary part of your care*** A good faith estimate is not binding and is subject to change based on individual medical needs. Any good faith estimate is valid for 30 days from the signature date of the form. A copy is available to you upon request.

Uninsured Patients

If you are without insurance payment is expected at the time of service. If you need to know pricing prior to receiving a service, please ask. If you are experiencing financial hardship, please do not hesitate to speak to the billing office regarding your situation.

Payment Plan Options for Uninsured Patients

There are two payment plan options available at Lifetime Skin Care Centers.

1. **Pay in full**- receive 20% off all services.
2. **Monthly Payments**-We will ask for 20 % of your total bill at the time of service if not paying in full.

Patients who agree to a payment plan will be asked to put a credit card on file for monthly payments. 20% of the original balance will be billed to the credit card on file monthly OR as otherwise indicated on an automatic payment form. Our billing staff will be happy to set up a payment contract with you

Overdue Balances

A balance becomes overdue in our office after 60 days of patient responsibility.
Failure to pay or establish a payment plan within these 60 days will result in transfer of the balance to a collection agency (where up to 40% of your balance will be added for collection fees) and possible dismissal from the practice.
***Please note: There is a $25.00 charge for returned checks written to our office.**

Appointment Cancellations

We reserve the right to charge a fee of $25.00 for failure to cancel an appointment "No-Show" or if you fail to advise us of your inability to keep your appointment prior to 24 hours before your appointment.

If you are receiving esthetic services, you will be required to sign a separate esthetic missed appointment form.

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Patient Printed Name Patient Date of Birth

____________________________________ ____________________________________

Patient/Agent/Guardian Signature & Date Witness Signature & Date

07/01/22

Patient Consent Form

I have read and understand the above information and have been given the opportunity to ask questions prior to my visit with the health care professional. By signing below, I agree to the above policy from this time forward, unless I revoke this signature in writing. I also agree to receive correspondence from this office and their business associates via phone calls, voicemails, emails, texting, portal access, and physical mail.

HIPAA Consent

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

Lifetime Skin Care Centers, LLC

With my consent, the Lifetime Skin Care Centers, LLC, may use and disclose my protected health information to carry out treatment, payment and healthcare operations (TPO). Please refer to the Lifetime Skin Care Centers, LLC's notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received a copy of the Notice of Privacy Practices and have the right to review it prior to signing this consent. Lifetime Skin Care Centers, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised copy may be obtained by forwarding a written request to Marsha Venable, Privacy Officer, 401 W. McGalliard Road, Muncie, IN 47303.

I consent to the policies and procedures that Lifetime Skin Care Centers, LLC, practices with regard to the following: (1) They may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance matters, and any call pertaining to my clinical care, including pathology and laboratory results, among others. (2) They may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. (3) By providing my email and cell phone number, I consent to receive information via email and/or text message including marketing information. (4)I have the right to request that Lifetime Skin Care Centers, LLC, restrict how it uses or discloses my PHI to carry out TPO. I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Lifetime Skin Care Centers, LLC's 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 disclosures in reliance upon my prior consent. If I do not sign this consent, Lifetime Skin Care Centers, LLC, may decline to provide treatment to me.

______________________________ _________________________________

Patient Printed Name Patient Date of Birth

____________________________________ _____________________________________

Patient/Agent/Guardian Signature & Date Witness Signature & Date

07/01/22

Patient Consent Form

Authorization to Release Medical Claims

AUTHORIZATION TO RELEASE MEDICAL CLAIMS INFORMATION

In order to be in compliance with HIPAA regulations regarding the billing you receive from our office, including patient billing statements, commercial insurance and Medicare, we must request your authorization to release your information and inform you of our financial payment policies. Without your signed authorization to release this information, we cannot file your insurance claims for you.

Contracted insurance will be filed at each visit and Non-contracted insurance will be filed as a courtesy. You will be expected to pay any unmet deductible, non-covered services and co-payments at the time of service. Patients with non-contracted insurance must also pay 20% of surgical procedures at the time of service. Payment options are available and may be established at your request. If you are billed for a service, and payment arrangements have not been made, full payment is due within thirty (30) days. Any balance that has become past due is subject to collection action. That patient is responsible for all collection agency fees (40% of balance), attorney fees, and court costs. A copy of this financial policy is available at the front desk. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

____________________________ ______________________________

Patient Printed Name   Patient Date of Birth

__________________________________ __________________________________

Patient/Agent/Guardian Signature & Date   Witness Signature & Date

Patient Consent Form

Medicare Auth to Release Medical Claims

IF YOU HAVE MEDICARE, PLEASE SIGN BELOW:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I request authorized MEDIGAP benefits be made on my behalf for any service furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

______________________________ _________________________________

Patient Printed Name Patient Date of Birth

_____________________________________ _____________________________________

Patient/Agent/Guardian Signature & Date Witness Signature & Date