Acknowledgement and Consent

____ (*Initial*) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name)______________________________, have read a copy of Vitalogy Skincare's Notice of Privacy Practices. (This document is available at the front desk or at Vitalogyskincare.com.)

____ (*Initial*) **CANCELLATION POLICY**

In fairness to other patients and your doctor, we require at least 24 hours notice to cancel appointments. Unless cancelled at least 24 hours in advance, you may be charged a fee for a missed appointment. This fee is not covered by insurance; it will be your responsibility to pay. Please help us serve you better by keeping your scheduled appointment.

____ (*Initial*) **RELEASE OF MEDICAL INFORMATION/ CONTACT PERMISSION**

In the event that Vitalogy Skincare needs to contact you (patient) regarding medical information about an appointment, lab/ biopsy result, medication, or any other reason, it is permissible to release your information:

- ☐ Leave a message on an answering machine
- ☐ Speak with spouse / significant other Name:__________________________ Phone number: ____________________
- ☐ Speak with other family members Name(s): __________________________ Phone number: _____________________

OR- I DO NOT authorize Vitalogy Skincare to release any medical information to anyone. ____ (Initial)

____ (Initial) **PATIENT PORTAL**

I **Do / Do Not** authorize Vitalogy Skincare to publish my benign results to my patient portal.

____ (*Initial*) **INSURED FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Vitalogy Skincare for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however I will be billed if any procedure is considered cosmetic per my insurance policy or not paid in a timely manner.

All procedures are subject to any applicable copays, deductibles and/or coinsurance.

____ (*Initial*) **UNINSURED FINANCIAL RESPONSIBILITY**

If you do not have insurance coverage, payment in full is due at the time of your visit unless payment arrangements are made prior to your appointment. Any elective procedure will not be done unless full payment is received at the time of your visit.

My signature below indicates that I have read and agree with all statements initialed above.

____ __________________

Signature of Patient (or guardian) Date