PATIENT ACKNOWLEDGEMENT OF OFFICE POLICIES

Insurance Information – Co-payments, Co-insurance, Deductibles and Balance Owed
Clear Dermatology will file your claim with your insurance if we participate with your insurance plan; otherwise, payment is required in full for all services at the time they are rendered. Should any services not be covered by your insurance, you agree to accept financial responsibility for said services. All applicable co-payments, co-insurance and deductibles and balance owed on your account are to be paid in full and collected at each and every visit. If you have not made arrangements with our Billing Department, prior to your visit, you will be asked to reschedule your appointment.

Patient statements will now be mailed to you every 30 days, and you will receive a text message from LQ PAY for payment convenience. If you have not paid your balance owed to us 60 days after insurance has adjudicated your claim, your CCOF will be charged. If balance remains unpaid after 61 days, your account will be placed with our collection agency. At that time, your account will be assessed a 31% fee on the balance owed, for which you are responsible to pay, along with the balance owed on your account.

If you have made arrangements with our Billing Department for a payment plan, you will be required to make your installment payment every month. In the event that you miss one payment, your account will be placed with our collection agency. At that time, your account will be assessed a 31% fee on the balance owed, for which you are responsible to pay, along with the balance owed on your account.

In the event of a default on any payment due to Clear Dermatology, you will agree to pay all costs of collection (31%), including any attorney fees (33 1/2%). Returned checks are subject to a $30.00 administrative fee. Your signature below signifies your understanding and willingness to comply with this policy.

Referral Information
If a referral is required by your health insurance plan, it is your responsibility to obtain the referral from your Primary Care Physician and assure it is available to be presented at the time of your visit. Additionally, it is your responsibility to keep track of the number of visits you have used on your referral, the expiration date of your referral and obtain new ones as needed. Should you fail to have a valid referral for your visit, insurance regulations require that you sign a financial waiver. In the event your insurance rejects any claims due to lack of valid referral, you will be responsible for payment and billed directly. Your signature below signifies your understanding, willingness to comply with this policy, and will serve as the required financial waiver in the event your insurance fails to provide a referral for your date(s) of service(s).

Insurance Cards and Photo Identification
All patients are required to provide valid insurance card(s), or a temporary print out at the time of their visit. Should you be unable to produce this documentation, insurance regulations require that you sign a financial waiver. All patients are also required to provide photo identification. Your signature below signifies your understanding and willingness to comply with this policy and that you are responsible for notifying our office of any changes to your insurance or contact information.

Virginia Law (Section 32.1-45.1 et.seq.)
I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the health care provider, it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 – 45.1 et. seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health providers are deemed to consent to tests and the release of the results to me, should I be similarly exposed.

HIPAA Policy
Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Clear Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.

Name Of Individual	Relationship To Patient

May we release Medical Information to: _____ Voice Mail at Home _____ Voice Mail at Work _____ Voice Mail on Cell Phone

Name of Patient: _____ Date of Birth:_____

Parent/Guardian's Name If Patient Is A Minor_____ Date of Birth: _____

Signature of Patient or Parent/Guardian:_____ Date:_____

CONSENT FOR PHI AND TPO

This consent is for the use and disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO).

Please review it carefully

- I understand that as part of my healthcare, Clear Dermatology originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

    - A basis for planning my care and treatment
    - A means of communication among the many health professionals who contribute to my care
    - A source of information for applying my diagnosis and surgical information to my bill
    - A means by which a third-party payer can verify that services billed were actually provided
    - And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

- I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

- With this consent, Clear Dermatology and its agents may call my home, my cell phone 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 items and any call pertaining to my clinical care, including laboratory results among others.

- With this consent, Clear Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

- With this consent, Clear Dermatology may e-mail or text my appointment reminders, patient statements as well as Text to Pay payment links. I have the right to request that Clear Dermatology restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

- By signing this form, I am consenting for Clear Dermatology to use and disclose my PHI to carry out my 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, Clear Dermatology may decline to provide treatment to me.

Name of Patient: _____ Date of Birth: _____

Signature of Patient or Parent/Guardian: _____ Date:_____

NOTICE OF INFORMATION PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

Please review it carefully

- Clear Dermatology may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

- Clear Dermatology is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health uses or court orders.

- An authorization from the patient is required for uses or disclosures for marketing purposes and for any disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

- Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided.

- Clear Dermatology will abide by the terms of the notice currently in effect at the time of the disclosure.

- Clear Dermatology reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Clear Dermatology will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

- Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.

- Any patient, guardian or personal representative has the right to inspect and obtain their medical record.

- Any patient, guardian or personal representative has the right to request amendments be made to their medical record.

- Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

- Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if the Practice does agree, the Practice must abide by those restrictions.

- Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the address and/or phone number listed above. All complaints will be addressed, and the results will be reported to the Privacy Officer.

- It is the policy of Clear Dermatology that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Name of Patient: _____ Date of Birth: _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Clear Dermatology

PATIENT ACKNOWLEDGEMENT OF CANCELLATION POLICY

Thank you for trusting your medical care to Clear Dermatology. When you schedule an appointment with Clear Dermatology, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than three (3) business days' prior to your scheduled appointment. This gives us time to schedule other patients who are waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy *effective 03/06/2026* below:

1. We require three (3) business days' notice in the event you need to reschedule or cancel your appointment.
2. If you miss an appointment and do not contact us with at least three (3) business days prior notice, we will consider this a missed appointment, and a $100.00 no-show fee will be assessed to you. This applies to late cancellations and "no-shows."
3. Any established patient who fails to show or cancels/reschedules an appointment without three (3) business days' notice a second time will be charged a $150.00 fee.
4. Surgical procedure appointments cancelled or rescheduled without three (3) business days' notice will be charged a $200.00 fee.
5. Cosmetic procedure appointments require a $180.00 deposit to reserve the appointment. This deposit will be applied toward the cost of your procedure and is nonrefundable if the appointment is missed, cancelled, or rescheduled without three (3) business days' notice.
6. A third No Show or cancellation/reschedule without three (3) business days' notice may result in dismissal from Clear Dermatology.
7. Any new patient who fails to show for their initial visit will only be rescheduled at the discretion of Clear Dermatology.
8. If you are late for an appointment, we will make every effort to ensure that you are seen as soon as possible, though the office visit may need to be shortened in length or rescheduled.

Our office sends text reminders for appointments as courtesy. **It is ultimately the patient's responsibility to remember their scheduled appointments. This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to charge with CCOF and collections.**

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee/late cancellation fee. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Clear Dermatology reserves the right to change, modify, add, or remove portions of this policy at any time. Your signature below and any future scheduled appointments with Clear Dermatology following changes to this policy constitutes your binding acceptance of such changes.

_____ _____

Patient Name **Date of birth**

_____ _____

Patient Signature **Date**