ALABAMA
DERMATOLOGY
AND SKIN SPECIALISTS

(Office Use Only) Patient Account Number _____

Credit Card on File Agreement

Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible and co-insurance.

Co-pays and estimated patient responsibility are due at time of visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Alabama Dermatology and Skin Specialist of the balance due, if any. At that time, the billing department will issue out one statement via the electronic portal which the patient will have 14 days to pay the balance or make other payment arrangements. After 14 days, the debit/credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the billing department will notify the patient. The patient will have an additional 30 days to arrange payment before the bill is subject to additional collection activity.

If you have any questions about the policy, please email your inquiries to admin@alderm.com

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I authorize Alabama Dermatology and Skin Specialists to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility.

If the provided debit/credit card has changed, expired or denied for any reason, I agree to immediately give Alabama Dermatology and Skin Specialists a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

☐ **Visa**	☐ **MasterCard**	☐ **Discover**	☐ **American Express**
Patient's Name (print):			
Date of Birth (mm/dd/yyyy):			
Cardholder Name (print):			
Last Four Digits of Debit/Credit Card Number		Exp. Date:	
Card Billing Address:			
☐ Please check this box if you prefer not to receive a statement and would like us to bill your debit/credit card immediately for any balances due after the processing of your insurance.			

Debit/Credit Card Holder's Signature:_____ Date:_____

OFFICE USE

Authorization Received by: _____ (Initials) Date: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Alabama Dermatology and Skin Specialists (ADSS) to use and/or disclose my protected health information as described below to:

Name and relationship to recipient(s): _____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE.**

2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

3) I may revoke this authorization at any time by notifying Alabama Dermatology and Skin Specialists in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.

4) ADSS agrees to maintain the confidentiality of my protected health information, however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Unless we have your written permission, we will not:

a) leave detailed voicemail messages with test results

b) be able to disuss your health information with anyone except the patient or legal guardian

☐ **I give consent to receive detailed voicemail messages from Alabama Dermatology and Skin Specialists at the following number(s):** _____

_____ _____

Signature of Patient or Legal Representative (if applicable) *Date*

_____ _____

Printed Name of Patient or Legal Representative (if applicable) *Relationship to Patient (if applicable)*

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PATIENT E-MAIL AND TEXT MESSAGE CONSENT

You may give permission to Alabama Dermatology and Skin Specialists (ADSS) staff to communicate with you by text message (also known as SMS) or e-mail. This form provides information about the risks of these forms of communication, guidelines for text and e-mail communication, and how we use text and e-mail communication. It also will be used to document your consent for communication with you by text message and e-mail.

1. How we will use text messaging or e-mail: We use this method to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. Your text messages may be forwarded to another ADSS staff member as necessary for appropriate handling. We will not disclose your messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices regarding private matters.

2. Risk of using text messages and/or e-mail: The use of text message and e-mail has a number of risks that you should consider. These risks include, but are not limited to the following:

a. Texts and e-mails can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Senders can easily misaddress a text or e-mail and send the information to an undesired recipient.
c. Backup copies of texts and e-mail may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect texts and e-mail sent through their company systems.
e. Messages can be intercepted altered, forwarded or used without authorization or detection.
f. Messages can be used as evidence in court. Text and e-mail messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

3. Conditions for the use of text messages and e-mail: ADSS cannot guarantee but will use reasonable means to maintain security and confidentiality of text information sent and received. You must acknowledge and consent to the following conditions:

a. IN A MEDICAL EMERGENCY, DO NOT USE TEXT, CALL 911. Do not text for urgent problems. If you have an urgent problem during regular business hours, please call our office. Urgent messages or needs should be relayed to us by using regular telephone communications.
b. Texts and e-mails should not be time-sensitive. While we try to respond to text messages daily, we cannot guarantee that any particular text will be read and responded to within any particular period of time.
c. You should speak with our staff to discuss complex and/or sensitive situations rather than send text or e-mail messages regarding such situations.
d. Text and e-mail messages may be filed electronically into your medical record.
e. Clinical staff will not forward your identifiable messages to outside parties without your written consent, except as authorized by law.
f. You should use your best judgment when considering the use of text or e-mail messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
g. ADSS is not liable for breaches of confidentiality caused by your or any third party.
h. It is your responsibility to follow up with our staff as warranted.

4. Withdraw of consent: I understand that I may revoke this consent at any time by so advising ADSS in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

☐ **I consent to receive text and e-mail messages from Alabama Dermatology and Skin Specialists and acknowledge I have read and fully understand this consent form. I understand the risks associated with the use of text messaging as a form of communication between ADSS staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that ADSS may impose to communicate with me by text message.**

☐ **I do NOT consent to receive text and e-mail messages from Alabama Dermatology and Skin Specialists.**

_____ _____
Signature of Patient or Legal Representative (if applicable) *Date*

_____ _____
Printed Name of Patient or Legal Representative (if applicable) *Relationship to Patient (if applicable)*