DOCS
DERMATOLOGY GROUP

Consent to Treat and Financial Policy

Please read carefully. This document explains your consent to treatment, how your health information is used, and your financial responsibilities as a DOCS Dermatology Group patient.

For the purpose of this consent, DOCS Dermatology Group ("DOCS") includes all facilities providing healthcare services, physicians, other healthcare providers, and staff of all subsidiaries and affiliates thereof.

1. Consent for Treatment

I consent to the provision of medical treatment, which may include, but is not limited to, routine examination, diagnosis/diagnostic tests, and general treatment to be performed by DOCS. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment. I understand that if further medical procedure(s) or surgery is required, I may need to sign specialized consents.

2. Use and Disclosure of Health Information

I authorize DOCS to use and disclose my protected health information in order to carry out treatment, payment, or healthcare operations. I acknowledge that I have been presented with the Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the Notice prior to signing this consent, that DOCS reserves the right to change its notice and information practices, and that I may obtain a copy of the revised notice by requesting one from the office or visiting our website.

3. Consent to Be Contacted

I understand that DOCS, its affiliates, and its agents may contact me by telephone (including my mobile phone) using a pre-recorded or artificial voice message, an automated telephone dialing system, text message, or email for any communication related to my appointment(s) and/or account(s).

4. Insurance and Patient Financial Responsibility

I authorize DOCS to bill my insurance carrier and to have any payment of insurance benefits made directly to DOCS. It is my responsibility to provide accurate and up-to-date insurance information promptly to ensure proper billing; if a claim cannot be processed due to delays in receiving this information, I will be held responsible for any outstanding balance and will need to submit a claim for reimbursement directly with my insurance provider.

I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s) — this also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payor. It is my responsibility to verify with my insurance company whether the provider is in-network to receive full insurance benefits, and I certify that the information I have provided related to my insurance coverage or other payment source(s) is correct.

I understand that cosmetic procedures are not covered or paid by healthcare plan(s), and I am responsible for any balance due for such services.

I also understand that an outside laboratory is used for pathology services, that billing for pathology services is separate from my DOCS billing, and that I am responsible for any balances related to pathology services.

5. Payment Responsibility for Uninsured and Non-Covered Services

If I do not have health insurance, I understand that payment is due in full at the time of service and that a driver's license or other valid identification will be required for my self-pay account. Until insurance eligibility is verified, my account will remain self-pay and payment will be required at check-in.

I acknowledge and understand that I am responsible for all self-pay charges, copays, coinsurance, deductibles, and any non-covered or denied services — including those denied due to medical necessity, diagnosis, or payor-specific conditions (for example, a non-allowable diagnosis or missing medical necessity support). Self-pay discounts may be applied to gross billable charges for full-fee services where eligible, but this does not remove my responsibility for any balances not paid or denied by my insurance plan.

6. Statements, Billing, and Collections

I acknowledge that payment may be requested on any outstanding balance when I arrive for care, and that patient statements will be sent for balances over $10.00. My balance is due in full upon receipt of my monthly statement, including coinsurance, deductibles, and any non-covered services as determined by my insurance plan. If I am unable to pay the full balance at once, I understand that flexible payment plans are available via the DOCS patient online bill pay page or by contacting the billing department at 866-680-8505.

If payment is not received after standard billing outreach, I understand my account may be referred to a collection agency and could appear on my credit report, and that future appointment scheduling may be paused until a balance placed with collections has been resolved. I understand DOCS is committed to working with patients to resolve billing questions, discrepancies, or payment arrangements in a way that is fair, clear, and manageable, and I can contact customer service at 866-680-8505 for support.

7. AutoPay

Applies to non-government payors (Medicare, Medicaid, Tricare patients are exempt)

Commercial insurance — card on file or deposit. If I am covered by a commercial health plan, I will be required to enroll in AutoPay at the time of service. As part of this financial policy, I authorize DOCS to maintain my credit card information securely on file. This card may be used to pay for any patient responsibility amounts not covered by my health insurance, including copayments, coinsurance, deductibles, and non-covered services. I understand that:

- My insurance company will be billed for services rendered.
- Once my claim is processed, my insurance provider will inform DOCS of any balance due.
- I will receive an email notification of the remaining balance and the amount to be charged to my credit card on file.
- My credit card will be charged 10 days after notification is sent.
- Individual payments will not exceed $300 per transaction and will be charged every 28 days until the balance is paid in full.
- If a charge to my card is declined for any reason, I agree to provide a new valid credit, debit, or HSA card within 10 business days; if a new payment method is not provided within this timeframe, a $25 declined card fee may be assessed.

- Patients with Medicare, Medicare Advantage (replacement plans), Medicaid, and Tricare are exempt from this policy.

If I choose not to enroll in AutoPay, a $100 deposit will be required at the time of service, in addition to any applicable copays. This deposit may be refunded after insurance has processed the claim, provided no balance is due.

8. Payments by Check and Credits

I acknowledge that if a personal check is returned due to non-sufficient funds, a $25 fee may be assessed. Until the returned payment and NSF fee are resolved, additional personal checks may not be accepted, and if two checks are returned on the same account, personal checks will no longer be accepted as a form of payment.

I acknowledge that patient or guarantor credits will be refunded unless applied to an upcoming appointment or an open insurance claim still in process.

9. Missed Appointments

Applies to all patients except those covered by Medicaid.

If I fail to attend a scheduled appointment, cancel, or reschedule with less than 24 hours' notice, I will be assessed a no-show fee as follows: Office Visit $50; Excision Appointment $150; Mohs Surgery $250. I understand that any applicable no-show or late cancellation fee will be assessed and eligible for payment via the card on file. If I do not have a valid credit card on file, I may be required to pay the outstanding fee in full prior to scheduling any future appointments. DOCS reserves the right to discontinue seeing me as a patient if I incur three consecutive no-shows.

Acknowledgment and Signature

This is a legal document. By signing, I agree that I understand and accept the terms on this form. I have the right to revoke the authorizations on this form at any time by notifying DOCS in writing, except to the extent that DOCS has already acted in reliance upon them. These authorizations will remain valid until I revoke them in writing.

Patient Name

Patient Signature Date