Consent and Conditions of Service

Ada West Dermatology

Ada West Dermatopathology

Patient Name:	Date of Birth:

As the patient or as the personal representative of the patient, I consent to the terms and conditions of this agreement. By signing below, I intend that the following apply to all my outpatient care provided by Ada West Dermatology. The terms "I," "my," and "you" in this agreement refer to the patient and to his or her authorized agent or legal representative. The term "Ada West" refers to outpatient care and services provided in facilities owned or operated by Ada West Dermatology and Dermatopathology, or by Ada West employees, medical staff, and independent contractors.

Consent to Healthcare Services

1. I consent to healthcare services provided by Ada West Dermatology and/or Dermatopathology. This includes services I receive provided by Ada West employees, medical staff, and independent contractors. Healthcare services include all healthcare and related medical, surgical, diagnostic, and therapeutic services, the implementing of physician orders, and all tests, studies, treatments and procedures ordered and performed in good faith. I may be asked to give additional consent for procedures, tests, or treatments that have additional risk. I understand that:
    - All healthcare services come with some risk, sometimes even the risk of serious harm. I accept this risk in the hope of a good result.
    - No promise has been made to me concerning a final result, outcome or cure.
    - Healthcare provider training may occur during my care. Any care provided by a trainee will be under the supervision of my provider or a healthcare team.
    - I can change my mind or refuse care. If I do, I must tell my healthcare team as soon as possible.

Independent Contractors

2. I understand that some of the people providing my care may be independent contractors and not employees or agents of Ada West. I understand that Ada West is not responsible or liable for the judgment, conduct, actions, or inactions of independent contractors.

My Protected Health Information

3. Ada West will keep medical records confidential, as required by state and federal laws. I have been offered a copy of Ada West's Notice of Privacy Practices, which describes how medical information may be used and shared and my rights. It may be revised from time to time, and I may ask to see a copy at any time.
4. I consent for my health information to be accessed by Ada West, or its subcontractors, needing it for treatment payment, or healthcare operations, without further approval from me.

Telehealth

5. I understand that I may receive care from healthcare providers at other locations using telehealth technology. In receiving telehealth services, I understand that:
    - I will be allowed to select my providers treating me through telehealth services to the extent possible but will not be able to select telehealth providers participating as part of my treatment teams.
    - Ada West safeguards medical information used in telehealth services, and only uses and shares this information as described in the Notice of Privacy Practices.
    - The technology used to deliver telehealth services meets industry security and privacy standards.
    - This technology could fail resulting in lost information and potential exposure of my health information notwithstanding the security measures in place.

Photographs and Recordings

6. I understand that Ada West may take photos/video/audio for security purposes, to help with my care, to assist with documenting my visit, or to improve quality of care.
7. I agree that I will not take pictures or videos in Ada West facilities without first obtaining the permission of everyone in the image or video. I understand that employees, providers, and others have the right to refuse being included in an image or video.
8. I understand that Ada West may restrict my ability to take photographs, videos, or audio recordings, especially in patient care areas.

Insurance and Government Payments

9. I consent for Ada West to file for insurance benefits to pay for my care.

- I transfer to Ada West (and to any healthcare provider for whom bills) the benefits of any insurance policy or other arrangement that may pay for my care. I consent for Ada West (and anyone it may assign as my legal representative) to negotiate claims with any insurance company or other payer to obtain payment for services provided to me.
- I consent for Ada West to deposit any money received against the charges of the facility (and of any other healthcare provider for whom Ada West bills.)
- I also specifically assign and transfer to Ada West all rights that are due to me under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq. ("ERISA"). This shall include, but not be limited to, the right under 29 U.S.C. Section 1132(c)(1) to request plan documents and to recover interest and attorney's fees.

10. I attest that any information I have used to apply for government benefits is correct. This includes Medicare, Medicaid, Tricare, or any other government program.
    - I consent for Ada West (or anyone else with medical information needed to process a claim for payment) to share it with government program administrators or any other payer.
    - I request these payers to make payments for all these services directly to Ada West.

What I am Responsible to Pay

11. As the patient or as a person signing for the patient who is otherwise legally responsible to pay for the care of the patient (the "Responsible Party"), I agree to pay for the following charges:
    - All amounts owed for healthcare services I receive from Ada West, as determined by Ada West or an independent contractor.
    - My share of the costs, including all co-payments, deductibles, and co-insurances that apply.
    - All charges for non-covered services.
    - Interest on unpaid balances that are more than 30 days past due or are sent by Ada West or an independent contractor for collection.
    - A service charge of $9.00 for any check or form of payment that returns unpaid.
    - All costs and attorney fees (if used) Ada West or an independent contractor incur if either refers my overdue bill for collection.
    - If I am the Responsible Party, I hereby consent to credit bureau inquiries for Ada West of the independent contractor's business needs, including any account management companies and debt collectors.

    Not applicable for VA or Military patients/dependents with Tricare, and Medicaid patients.

12. I understand that if I am a temporary caregiver for the patient (such as a nanny, youth leader, foster parent or some law enforcement agencies), I may not be financially responsible for the patient's care. I recognize that this statement about temporary caregivers is not an opinion by Ada West whether I am or am not a temporary caregiver or whether I am responsible to pay the patient's care.
13. I agree that any overpayment I make will be applied to any other accounts with Ada West owed by me with any excess being refunded to the proper party in accordance with Ada West policy.

Consent for Text, Digital and Email Communications

14. I hereby consent to receiving text, digital, and email communications (including auto-dialed, artificial, and pre-recorded messages and calls) to my cell phone number, email address, and any other telephone numbers provided during any interaction, agreement or communication with Ada West, independent contractor, or their agents, and contractors. I acknowledge that text and email communications are not a completely secure method of communication and accept the risk that my information may be intercepted and read by a third party.

Changes to This Consent

15. If I make changes to this consent, they are not valid.

By signing below, I understand and Agree to the Following:

A. I have had the opportunity to read this agreement, have it read to me, and I understand what I am agreeing to.
B. I can ask for and receive a copy of this agreement.
C. This document will remain in effect unless I revoke it in writing.

I have received or been offered a copy of Ada West's Notice of Privacy Practices.

Date:	Patient or Representative	Print Name