Welcome to Legacy Dermatology Group!

We appreciate the opportunity to take excellent care of you and your family.

LDG Financial Policy

IDENTIFICATION: All Patients must complete the necessary patient information forms, consents & provide valid ID and medical insurance card prior to evaluation by a physician or other health care provider. These documents must be updated annually.

CHARGES: All co-payments and charges for cosmetic services are required to be paid in full at the time of service. Applicable copays may be collected at check-in. As a courtesy to you, LDG will bill your insurance company for medical services. Patients are responsible to pay any remaining balances in a timely manner including uncovered services. For services which are denied by medical insurance, payment will be billed to patients directly and patients accept full responsibility for the balances due after insurance processing.

PAYMENT ON FILE POLICY: Regardless of insurance coverage, all patients are required to have a valid credit card, HSA or e-check on file with LDG. Credit cards are securely stored in a PCI-compliant payment gateway and card numbers are not visible to staff. LDG will notify patients via emailed statement 1 week prior to charging the card on file.

By signing this policy, you authorize LDG to charge the payment on file for balances due. For patients who do not have email, LDG will notify you via phone of the balance. Payment on file will be charged 7 days from notification. For patients whose payment methods decline, LDG will notify them via phone and/or email of payment declination. Declined credit cards may be subject to an office fee.

PAST DUE BALANCES: Patients that have an unpaid balance beyond 4 months of 1st notification of payment due will have their account placed with an external collection agency. A 25% service charge will be added to the unpaid patient balance to cover collection costs. Patients who fail to pay the collection agency in a timely manner may incur additional fees including reasonable attorney fees if incurred by the collection agency. Patients who fail to pay their LDG debt may be dismissed from the practice.

COSMETIC PROCEDURES: Due to the specialized nature of our medical practice, LDG provides some services that are not covered by medical insurance plans. It is the patient's responsibility to know what is covered under their insurance plan. LDG does not submit cosmetic procedure claims to medical insurance. If a procedure is performed, and insurance considers it cosmetic, the patient will be held responsible for the charges.

REFERRALS: Patients who are covered under HMO health insurance plans are responsible for obtaining the required referral prior to the office visit. Failure to obtain a referral renders the patient responsible for all charges pertaining to the medical visit.

MINORS: The adult accompanying a minor (or the parent/guardian) is responsible for full payment of all copays and deductibles. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre-authorized verbally or in writing.

NO-SHOW POLICY: Patients who fail to arrive for their appointment deprive others of medical attention. Patients will be charged a $50 fee for any scheduled appointments or $100 for any procedure (including surgery) that is not cancelled or rescheduled at least 24 hours prior to the appointment time. Patients who do not arrive for their scheduled appointments more than once may be referred to another practice.
INSURANCE: LDG reserves the right to notify your health insurance company of nonpayment of patient insurance fees such as copays, coinsurance, remaining balances and deductibles that apply. LDG does not participate with Medicaid.

Protected Health Information and Privacy Policy

As part of your healthcare, Legacy Dermatology Group originates and maintains electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment, and payment for services information. We use this information to plan your care, communicate with other health professionals who contribute to your healthcare and submit your diagnosis and treatment information for payment from insurance companies or others

AS PERMITTED BY STATE OR FEDERAL LAW, I give Legacy Dermatology Group CONSENT to do the following:
1. To disclose, as may be necessary, my protected health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers (such as: referrals to or consultation with: other healthcare professionals, laboratories, hospitals, etc.) for my treatment and/or healthcare.
2. To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information needed for planning your care and treatment.
3. To submit the necessary information to my insurance company(s) for coverage verification as well as the diagnosis and treatment information to insurance company/s, other agencies and/or individual(s) for payment of services.
4. To leave appointment reminders or information necessary for my treatment or payment on my answering machine, voicemail, via text message, or with a member of my household. The information will be the minimum necessary.
5. To discuss my health or payment information with selected family members or other persons who are or may be involved with my healthcare treatment or payments.

By signing this consent, I **agree to update Legacy Dermatology Group on any medical history and medications and notify them at every visit of any changes to my health**. I understand that my treatment is not a condition of signing this authorization.
I fully understand and agree to this consent and acknowledge the above rights and disclosures.

Consent for Treatment and Communication

CONSENT FOR EXAMINATION: I understand an examination will be necessary and I consent to the partial or complete examination as part of my medical care. I understand the findings will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not Legacy Dermatology Group.

CONSENT FOR PHOTO DOCUMENTATION: I consent to the use of photo documentation as part of my protected health information. Photos of my progress and disease state may be used to communicate details between providers, track progress and verify details of procedures.

CONSENT FOR TREATMENT: I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments, including biopsies and cryosurgery, that may be considered advisable or necessary in the judgment of Legacy Dermatology Group. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

CONSENT FOR ELECTRONIC COMMUNICATION: I hereby consent and state my preference to have my physician and other staff at LDG communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to: appointments, practice news, information and billing statements. I further understand that email and standard SMS messages are not secure methods of communication, and using these methods may increase the risk of my private health information being intercepted and read by a third party. I agree to take responsibility for my healthcare by using my HIPAA compliant portal when discussing specific treatment, procedures or prescriptions.

CONSENT FOR INFORMATION LEFT ON VOICEMAIL: I hereby consent to telephone messages regarding my appointments, prescription renewals, lab results and all protected health information being left on my personal voicemail for the phone numbers I provide.

I hereby consent to keep LDG up-to-date on my medical history and medications and notify them at every visit of any changes to my health.

COVID-19 Risk Consent

I understand that I am opting for an elective treatment or procedure that is not urgent and may not be medically necessary. I understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact.

By signing this, I attest that I have not experienced fevers, chills, shortness of breath, cough, loss of taste or smell for the last 2 weeks. I attest that I have not been exposed to anyone with known COVID19 or the above mentioned symptoms.

I agree to wear a mask at all times while at Legacy Dermatology Group. Due to the infectious nature of the virus and in order to protect the staff at Legacy Dermatology Group, I agree that **I will not talk during procedures in which my mask must be removed.**

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment can lead to a higher chance of complication and death.

I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment.

I hereby consent to the LDG policies listed above.

I understand that these consents are valid from Jan 1, 2022 to December 31, 2022.

Name of Patient:

PRINT_____

Signature _____

Parent or Guardian:

PRINT_____

Signature _____

Date: _____