DERMATOLOGY ASSOCIATES OF SW WASHINGTON PLLC

JOEL DATLOFF, MD
ELIZABETH S. DAWSON, MD
LAURA BRANDT, PA-C
MARY BURNELL, MPAS, PA-C

Patient Policies

THE FOLLOWING ARE INTERNAL POLICIES SET IN PLACE BY THE ADMINISTRATION OF DERMATOLOGY ASSOCIATES OF SOUTHWEST WASHINGTON.
SIGNATURE IS REQUIRED BEFORE SERVICES CAN BE PROVIDED.

CONSENT FOR MEDICAL SERVICES
I authorize Dermatology Associates of SW WA to render treatment to me or my dependents for dermatological care or medical procedures as deemed medically necessary for treatment as indicated.

PATIENT COMMUNICATION
I understand that messages potentially including confidential information may be left on my voicemail or answering machine at the preferred number(s) I have provided to Dermatology Associates of Southwest Washington. Dermatology Associates of SW WA may also communicate with you via e-mail, text message, or letter to your home address provided such method complies with applicable HIPAA communication standards.

PATIENT PORTAL
We will also utilize our secure patient portal to communicate with you. This portal allows you to communicate with us easily and safely, according to your schedule. Using your own secure password, you can log into the online patient portal 24 hours a day, 7 days a week, from the comfort and privacy of your home or office.
Please note - online communications should not be used for life threatening, emergency communications, or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

After you have completed registration for your patient portal, you will be able to do the following:
- View upcoming or past appointments
- Update your contact information
- Communicate with the office by sending and receiving secure messages
- Receive reminders through your email
- Receive lab and pathology results
- View selected health information (allergies, medications, current problems, past medical history), and submit update requests.

The following will NOT be accepted through the Patient Portal:
- Diagnosis or treatment; no medical advice or consultations will be offered over the portal. Diagnosis and treatment can only be offered in person with a provider.
- Emergency communication. Communication on the portal is restricted to non-urgent issues.
- Requests for medication refill.

Note: Communication via the Patient Portal may be included in your permanent medical record.

Dermatology Associates Response Time:
Our system will notify us when we have messages. Reasonable efforts will be made to respond to portal inquiries within one (1) business day, but no later than three (3) business days, after receipt. Response time may be longer if the Patient Portal service is interrupted for maintenance, upgrades, or emergency repairs related to events beyond our control. In this respect, you agree not to hold Dermatology

Associates, its providers or any of its staff, in any way liable or responsible to you for any such modification, suspension, or disruption of the Patient Portal.

Protecting your private health information and risks:
While we work hard to ensure that all communication through the portal is secure, it is imperative that Dermatology Associates has your correct email address and that you inform us of any changes to your email address. It is your responsibility to make sure your login information is protected from unauthorized access. If you think someone has learned your password, please promptly change it, or call our office. Your email address is confidential and protected information, Dermatology Associates will never purposefully share this information with a third party.

Availability of the Patient Portal
Access to this secure Patient Portal is an optional service, and may be suspended or terminated at any time, and for any reason. If service is suspended or terminated, we will notify you as promptly as possible.

Access for children 13 -17 years old:
In Washington State, a minor has the right to consent to release certain information that is in their record. However, it is not possible to block sensitive information in the patient portal record, so no medical record access will be granted to parents for a child 13 years to 17 years of age.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY
I do, hereby authorize payment of my insurance benefits, including authorized Medicare benefits, basic and major medical for the services I receive, to be made directly to Dermatology Associates of SW WA.

PATIENT IDENTIFICATION REQUIREMENT
I understand that due to Federal (red flag) rules, Dermatology Associates of SW WA is prevented from filing to my insurance without proof of identification. I will be expected to present a valid photo ID and insurance card(s) at every office visit. I will also update any changes to my address, telephone number(s), and insurance if they have changed since my last visit. I understand that I will be asked to update my demographics and signatures annually.

MINOR PATIENTS
All minors are required to have a parent/legal guardian present with them for each appointment. By law, we are required to have consent from a legal guardian to provide treatment to a minor. If a parent or guardian is unable to attend an appointment with the minor, then a signed and dated authorization to treat a minor is required prior to the appointment. If a minor comes to the office unattended and we do not have a signed and dated authorization from the parent/legal guardian, we will be unable to see the patient at that time, and the appointment will have to be rescheduled.

FINANCIAL RESPONSIBILITY

- I understand that, although Dermatology Associates of SW WA will file a claim to my insurance plan(s), I am expected to pay my copayment, coinsurance, deductible and non-covered services amount at the time services are rendered.
- I agree to pay a $25 fee if I fail to pay my copay at the time of check-in.

- I acknowledge that Dermatology Associates of SW WA does not guarantee payment of my claim by my insurance plan, and that it is my responsibility to know the provisions of my insurance.
- I understand that not all procedures are deemed 'Medically Necessary' by insurance carriers and can be considered cosmetic.
    - For example - Skin tag removal or correction of dark spots may not be a covered service.
    - I understand that I would be responsible for payment of such services. I am ultimately responsible for any unpaid balance or non-covered service.
- I agree to pay all costs of collecting, securing, or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees. Patients who are sent to collections will be discharged from the practice.
- I also understand that any prior unpaid balances on my account must be paid in full before being seen by a provider. If my prior balance cannot be paid in full, I will speak with a Billing Specialist at Dermatology Associates of SW WA to make a payment arrangement before services can be rendered.
- I also understand that if Dermatology Associates of SW WA does not participate with my insurance plan, I will be expected to pay in full for my services. It is my responsibility to know if Dermatology Associates of SW WA is in network with my insurance plan.
- I understand that payments to Dermatology Associates of SW WA can be made by cash, checks and all major credit cards. I also acknowledge that returned checks will be subject to a non-sufficient fund fee of $35.00.

MEDICARE BILLING

I understand that Medicare may not cover some of the services that my doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

SELF PAY PATIENTS (PATIENTS WITHOUT INSURANCE)

I understand I should be prepared to pay in full at the time of each visit. Since Dermatology Associates of SW WA is unable to predict what services will be performed prior to your appointment, the practice requires that you make a down payment of $150.00 at check-in. At the end of your appointment, your final fee will be determined and your $150.00 down payment will be applied. Any additional monies owed will be collected or refunded to you at that time.

REFERRALS/AUTHORIZATIONS

I understand that if my insurance requires a referral or an authorization, I am responsible for obtaining the referral prior to my visit. If I do not have a referral or authorization at the time of my visit, I may be rescheduled or sign a waiver of financial responsibility. In such case I understand that full payment will be required at the time of service.

COSMETIC SERVICES

Cosmetic services are not a covered benefit under insurance plans. I understand that to make an appointment for cosmetic services, I will be expected to pay in full at the time services are rendered.

LATE ARRIVALS / MISSED APPOINTMENTS

We understand that emergencies, work, or family obligations can alter patient's plans without warning. We also recognize, however, that missed appointments ("No shows") and late cancellations affect other individuals' ability to access medical care in a timely manner.

Appointment Cancellation

I understand that it is my responsibility to notify Dermatology Associates of SW WA if I need to cancel my appointment at least 24 hours prior to scheduled appointment time. This is required to allow time to schedule another patient in that appointment spot. To cancel appointments, call (360) 254-5267 and leave a detailed voicemail if unable to speak with a person (after hours).

No Show Policy

A 'No Show' is someone who misses an appointment without cancelling it, or cancels with less than four hours' notice prior to the appointment. If you no show an appointment, we will record this in your medical record. If you no show your New Patient appointment, you may not be allowed to reschedule. I acknowledge that if I miss appointments without sufficient notification that I may be charged a $45 fee, or I may be dismissed from the practice for non-compliance of our policies.

Late Arrivals

All patients are expected to show up at least 15 minutes prior to their appointment time to ensure all required documents are completed, and all necessary information is updated in the patient record. New patients showing up AT or AFTER their appointment time will be asked to reschedule. I understand that if I arrive late for an appointment, I may be asked to reschedule or wait for another open appointment time on that day's schedule.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have access to Dermatology Associates of SW WA's 'Notice of Privacy Practices' that details how my personal health information may be used, disclosed, and my rights as permitted by federal law. I understand that this notice is posted for my benefit in the reception areas, and is also available on the website of Dermatology Associates of SW WA (www.vancdermassoc.com).

e-PRESCRIBING CONSENT

I acknowledge that Dermatology Associates of SW WA utilizes electronic health records and will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my pharmacy provider. To enable electronic prescriptions to my pharmacy, I grant Dermatology Associates of SW WA my permission to access my medication history to view current and past prescription information.

PRESCRIPTION REFILLS

Please request all medication refills directly from your pharmacy. They will contact us if approval is needed for a refill. Allow at least three (3) to five (5) business days for your refill requests.
Please note, we will only refill prescriptions during our normal business hours.
We will not refill prescriptions if you are overdue for a follow up appointment.
Generally, no refills will be given for patients who have not been seen in the practice during the past twelve months for that specific prescription.

LAB SERVICES

If you have labs or tests performed at our office your lab results will be published to the Patient Portal within 48 hours of receipt of results. If you do not see your results on the portal within 3-4 days, please make sure to call for your results. Please do not assume that your results are negative if you have not

heard from us; it is possible that we have not received your results, or that we were unable to get into contact with you.
I am aware that my laboratory/pathology services are billed separately from Dermatology Associates of SW WA. I will receive a separate statement from another lab or pathologist.
I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason. Charges for the lab tests are billed separately and not included in the charges for my office visit.
In addition, it is my responsibility to contact my insurance plan to determine what laboratory is in network.

_____
Patient Printed Name

_____ _____
Patient or Parent/Guardian Signature Date:

_____
Parent/Guardian Printed Name (if applicable)