ASPIRE
DERMATOLOGY & AESTHETICS

WELCOME TO ASPIRE DERMATOLOGY & AESTHETICS
AUTHORIZATION & AGREEMENTS OF MEDICAL TREATMENT

Please initial:

_____ CONSENT FOR EXAMINATION: I understand that an examination will be necessary, and I consent to the partial or complete examination as part of my medical care. I understand that the examination 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 Aspire Dermatology & Aesthetics, or assistants. I hereby release my examiner from all responsibility in connection with the examination.

_____ I authorize Aspire Dermatology & Aesthetics to send any specimen obtained through the course of my treatment to an outside lab. These labs analyses are separate services from those received in this office and will be billed separately by the lab. Aspire Dermatology & Aesthetics will make every effort to send specimens to labs within the insurance network, however, it is my responsibility to inform Aspire Dermatology & Aesthetics of the lab that is contracted with my insurance. I understand that I will be billed separately from both Aspire Dermatology & Aesthetics (for the service of obtaining any specimen) and the lab (for the analysis of said specimen).

_____ I authorize Aspire Dermatology & Aesthetics to receive, mail, fax, and/or e-mail my records to another physician or medical facility in the course of my diagnosis and treatment.

_____ I will present my most current insurance card(s) and photo ID when I check in for each appointment.

_____ I understand that it is my responsibility to notify Aspire Dermatology & Aesthetics of any changes to my information including, but not limited to: mailing address, phone number(s), insurance policies, or any other information that Aspire Dermatology & Aesthetics needs to be able to contact me, collect payment, and/or otherwise carry out my treatment.

_____ I authorize Aspire Dermatology & Aesthetics to access my pharmaceutical records and history.

_____ I acknowledge that it is my responsibility to understand my insurance policy and benefits. I am responsible for ensuring that the provider I am receiving services from is contracted (in-network) with my insurance. It is my responsibility to obtain a referral and/or prior authorization/precertification if required by my insurance. Failure to understand my policy, benefits, network, and/or insurance requirements will not relieve me of my financial responsibility to Aspire Dermatology & Aesthetics. Aspire Dermatology & Aesthetics will make every effort to understand and explain my benefits, confirm the provider is contracted with my insurance, obtain any necessary referrals and/or prior authorization/precertification, and satisfy all insurance requirements for service. However, I acknowledge that is my responsibility to ensure that everything is satisfied correctly, and I will not hold Aspire Dermatology & Aesthetics liable for any failure on my part.

_____ I authorize Aspire Dermatology & Aesthetics, and their agents, to contact me by any method that I provide contact information for including: telephone calls (landline and wireless), voicemails/voice messages, text messages, emails, and mail for various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing statements. I understand that email and standard SMS messaging are not secure methods of communication. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. I understand that if I do not want Aspire Dermatology & Aesthetics, or their agents to contact me in a certain way, then I will not provide the applicable telephone/wireless cellphone number, email address, or mailing address. If I provide any contact information, then I expressly consent my authorization for Aspire Dermatology & Aesthetics, and their agents, to contact me by these means.

I have read and understand the terms of services and agree to abide by its guidelines:

Patient Name _____ DOB: _____

Signature (Patient or Guardian) _____ Date: _____

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