Daniel S. Hurd D.O., F.A.O.C.D.
Angie Hurd, PA-C
Joe A. Sheets, PA-C
Kelsey Wolford, PA-C
Emily Woodall, PA-C

Please circle yes or no after each statement:

I have had the opportunity to review and agree with the privacy practices of New River Dermatology.	**Yes**	**No**	
New River Dermatology may speak to my spouse regarding ANY of my medical information.	**Yes**	**No**	**N/A**
Do we have your permission to leave your test results on a voice mail?	**Yes**	**No**	**N/A**
Are there any other family members you authorize to receive your information?	**Yes**	**No**	

If so please list their names and phone numbers below:

Name _____ Phone _____

Name _____ Phone _____

APPOINTMENTS: We will see patients by scheduled appointments, and our office staff will make every effort to schedule your appointment at a time that is most convenient for you. If you need to cancel your appointment, please call at least 24 hours in advance of your scheduled time so that we may provide that appointment time to another patient. If you are more than 10 minutes late for your scheduled appointment, your appointment will be rescheduled. ***We will confirm your appointment prior to the scheduled date and time. Failure to show for a confirmed appointment will result in a $50.00 no-show fee that is not billable to your insurance.***

CONSENT FOR HIV, HEPATITIS B OR C TESTING: New River Dermatology is required by Section 32.1-45.1 of the Code of Virginia (1950), as amended, to give you notice that if any New River Dermatology health care provider, worker or employee should be directly exposed to your blood or body fluids in any way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (AIDS virus) as well as Hepatitis B and C. A physician or other health care provider will notify you of the results of the test. Under VA Code Section 32.1-45.1 A, you are deemed to have consented to release of the results to the person exposed. New River Dermatology will only be responsible for any expenses incurred for this testing under the circumstances listed above.

CONSENT FOR BIOPSY AND PATHOLOGY: New River Dermatology will at times take a biopsy of your skin for further evaluation of your medical condition. It is important to your health that pathology is done on any skin removal to ensure that there is no cancer present. You may receive a pathology bill (depending on your insurance coverage) if you have had any skin removed today.

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SELF PAY/NON PARTICIPATING INSURANCE POLICY:

New River Dermatology does not participate with all medical insurance companies. It is your responsibility as a patient/guardian of a patient to know which physicians are participating providers with your medical insurance policy. You can contact your insurance company and they will tell you which physicians in the area are under contract with them. If your insurance requires a referral, it is your responsibility to ensure that we have received that referral prior to your scheduled appointment. If we have not received your referral prior to your appointment you will be responsible for the full amount of any charges not covered by your insurance.

Examples of insurance companies that we **do not** participate with include but are not limited to: Alliance, Mamsi, Aetna (AEP HMO) and some Medicaid plans. As a non-participating physician we do not have a contract with these particular insurance companies. This means that your insurance company may not pay for any medical charges or may pay at a reduced rate for services that are rendered at New River Dermatology. Payment, in full, is due at the time services are rendered to you.

With the exception of Medicaid, we will file your insurance claim on your behalf with your current insurance company. If your insurance company pays any portion of your claim, even though we are non-participating providers with them, you will be reimbursed any monies due to you when our billing company receives that insurance payment.
By signing below, I understand that if New River Dermatology is a non-participating provider with my particular medical insurance, or I am Self-Pay patient; that I am responsible for all or a percentage of any services rendered by New River Dermatology.

PAST DUE ACCOUNTS: Payments not received upon the date of medical service, will be considered delinquent, and interest at the rate of 18% will accrue, until such time balance is resolved. You further agree to be financially responsible for any collection cost associated with the balance recovery due our office, i.e. collection agency fees; attorney fees; court costs; and/or certified mailing cost. Any personal check declined by your banking institute, will result in a $50 fee, allowable under Virginia law. Should civil litigation be required to necessitate the collection of any delinquent amounts or to resolve any disputes, you agree to the following court venue: *Montgomery County, Virginia.*

By providing your cell phone as a means of contact and communication, you hereby authorize our office and our business associates, to also communicate with you at this number. This would include, but not limited to, communication from our collection agency, and/or collection attorney. You understand that you may incur an expense during cell phone communication.

MEDICARE AND PRIVATE INSURANCE REGULATION CHANGES: When you are seen for your regularly scheduled skin exam and need to have a PROCEDURE PERFORMED SUCH AS A BIOPSY, the procedure must be scheduled on a separate date. You will not be charged another office visit upon your return, but only for the procedure(s) being performed. Procedure(s) may have additional charges depending on your insurance coverage/plan. We apologize for any inconvenience this may cause our patients, but we do have to abide by these insurance regulations or be penalized.

BY SIGNING BELOW, I ACKNOWLEDGE AND CONSENT TO THE ABOVE POLICIES AND PROCEDURES OF NEW RIVER DERMATOLOGY:

Patient or Parent/Guardian Signature _____Date_____

Patient Printed Name_____