Elizabeth A. Liotta, MD, LLC

Clinical and Cosmetic Dermatology
77 THOMAS JOHNSON DRIVE, SUITE C
FREDERICK, MD 21702
301-668-3004

PATIENT AGREEMENT FORM

PLEASE READ, INITIAL WHERE REQUIRED, AND SIGN THIS STATEMENT PRIOR TO TREATMENT

1. Consent for Treatment: I, or my representative, agree to have Elizabeth A. Liotta, MD, and associate Health Care Providers evaluate and treat my condition. I understand that, for certain treatments, I may be asked to sign an additional informed consent form.

2. As a patient of Elizabeth A. Liotta, MD, LLC I understand it is my responsibility to:

INITIAL_____ provide accurate and complete information regarding my medical needs, medical history, medications, demographics, and health insurance, and to report any related changes to the physician and/or staff.

INITIAL_____ provide proof of identification (driver's license) and current insurance information prior to or upon arrival for my appointment (parent's information if the patient is a minor), for every appointment.

INITIAL_____ provide a valid referral (if required by your insurance company) prior to or at the time service. If a valid referral is not available at the time of my appointment, I may be asked to reschedule.

3. Payment for Services: I understand that Elizabeth A. Liotta, MD may bill my health insurance plan for the care I receive. I agree that payments from my health plan may go directly to Elizabeth A. Liotta, MD. If I should receive the payments, I understand that I will be responsible for paying Elizabeth A. Liotta, MD.

I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. Payment on all statements I receive is due upon receipt, and all outstanding balances, insurance deductibles, and co-pays are expected to be paid in full prior to treatment.

I understand and agree that if my insurance plan does not pay for the services provided, I will have to do so. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days may be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

A fee of $30.00 will be imposed for any checks returned due to insufficient funds.

4. Notice of Privacy Practices: A Separate Form is Attached for you to take with you.

INITAL_____ I have received the Notice of Privacy Practices.

5. Missed Appointment Policy: I understand and agree that I may be charged a cancellation fee if I do not provide 24 hours' notice when canceling an appointment (exceptions are made for emergencies), or should I leave after checking in for an appointment without notifying the reception desk (if the provider is running more than 30 minutes late the patient is given the option of rescheduling with no fees being charged).

6. Telephone Consumer Protection Act: I agree that by providing my landline or cellphone number(s), I am giving express consent for Elizabeth A. Liotta, MD, LLC its staff, employees, and independent contractors and agents to contact me at these numbers, or, at any number that is later acquired for me and to leave pre-recorded messages regarding scheduling or scheduled appointments or my account.

I have read, understand, and agree to the items as defined in the above Patient Agreement Form:

(SEAL)_____
Print Name of Patient or Parent/Legal Guardian Relationship

(SEAL)_____
Signature (Type Name here if completing form online) Date

ELIZABETH A. LIOTTA, MD, LLC

NOTICE OF PRIVACY PRACTICES

This practice has implemented the following policies and procedures to ensure the confidentiality of your personal and/or medical information. Federal and state laws require us, to maintain the privacy of your health information.

Your physician(s) and all other employees working in the practice will keep any information related to you (medical and/or non-medical) in a confidential manner. However, so that we may provide you with appropriate medical care, for general practice operations and or for the purposes of obtaining payment, we will, at our discretion provide information pertaining to the treatment you received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health care related entities. This information will be submitted through the following mechanisms: US Postal Service, fax submission, Internet submission, voice mail and/or personal communications. The following is a list of the most common types of entities that we most typically would provide personal health related information. This list is not an all-inclusive list. Other entities may be added to this list.

- Physicians and non-physician providers (i.e. physician therapist, nutritional counselors) who work outside of this practice.
- Medical facilities (i.e. hospitals, outpatient centers).
- Laboratories for the purposes of running medical tests.
- Other health care providers, such as pharmacies, durable medical equipment suppliers, ambulance services.
- School health departments.
- Insurance companies (or third party administrators) for the purpose of obtaining payments or general case management.
- State or Federal agencies that require the submission of specific health related information.
- Billing services.

We may need to contact you, by phone, to discuss your appointments, test results, treatments, referrals, account balance and/or to return your phone call. We will first attempt to contact you at home, however if you are not available and you provide us with your work number, we will attempt to contact you at work. If you are not available, we will leave a message for you to either call the office for a specified reason (i.e. discuss test results, account balance) or we will remind you of your appointment time.

In the event you do not pay all of your charges in full at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail recall cards to your home noting that you need to contact the office to schedule an appointment. Periodically, we may mail test result information to your home. We will use the home address you provided us with at the time you register with the practice.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirements. If necessary for obtaining payment, we will provide credit bureaus and/or collection agencies with your account information.

When you arrive at our practice for your appointment, we will ask you to sign in and note your arrival time. We will do our very best to see you promptly. However, there may be times when your provider is running behind schedule and you will need to wait in the waiting room.

If you would like information sent to another physician or medical facility, you may be asked to authorize the release of this information, in writing (we will provide you with the necessary form to complete). Also, you must provide written authorization for the release of information to your life or disability insurer.

You may review and/or obtain a copy of your medical record. You may request, in writing, changes be made to your medical record. We will review your reason(s) for such a request and if we agree, will make the change(s). If we do not agree with your request, you are entitled to have your statement added to the record. Also, you may request information regarding who we have disclosed your medical information to for purposes other than treatment, payment and health care operations.

Please provide us with current information regarding your phone numbers (work and home) and home billing address. This will allow us to make the correct contact when trying to reach you.

When necessary these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the policies and/or procedures noted above, please contact our practice manager at the above address and phone number to report any and all concerns. We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. If you believe we have not maintained the privacy of your records, you may file a complaint with the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for filing a complaint.