William E. Freeman, M.D.
DERMATOLOGY • DERMATOLOGIC SURGERY

Patient Consent and Questionnaire
(Read document in its entirety before signing)

1. Please list the family members (including spouse, children) or other persons, *if any*, whom we may inform about your general medical condition and your diagnosis (please list phone #'s if different from home):
   _____
   _____
   _____

2. Can messages (i.e. appointment reminders) be left on your home answering machine?
   Yes___ No _____ No Answering Machine Available _____

3. Can we contact you at your workplace or leave a message on your voicemail?
   Yes ____ No ____ N/A ____

4. Can we contact you via email? Yes ____ No ____ Via Text Message? Yes ____ No ____

5. It is Dr. Freeman's office policy to send ***all*** specimens (no exceptions) of the skin removed by biopsy or other surgical method to an outside pathology laboratory. You will be billed a separate charge by the laboratory. Your signature below indicates that you understand and comply with Dr. Freeman's policy regarding outside laboratory services.

6. It is Dr. Freeman's office policy that minors must be accompanied by a parent and/or legal guardian on their initial office visit. Minors must be accompanied when having a surgical procedure. After the initial office visit, minors of driving age can come unaccompanied (non-surgical procedures) as long as parent/guardian consents that said minor is understanding of treatment, prescriptions, follow up care instructions.

7. It is Dr. Freeman's office policy to confirm office appointments by telephone, email or text messaging.

8. It is Dr. Freeman's office policy to submit necessary personal health information (PHI) to insurance companies for purposes of billing and receiving payment.

9. It is Dr. Freeman's office policy to mail monthly statements to your residence.

10. It is Dr. Freeman's office policy to mail monthly dunning letters when necessary to collect for past-due accounts. Accounts are considered past due 30 days from the initial date of service.

11. It is Dr. Freeman's office policy to collect all medical fees incurred. If incurred fees remain unpaid, your account will likely be referred to an outside entity for further collection process. The nature of your medical history and medical record will remain confidential and will be retained by the practice; however, personal identifying information such as name, address, phone number, responsible party, social security number will be released.

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12. You have the right to request, in writing, how Dr. Freeman uses or discloses your personal health information (PHI) to carry out treatment, payment and health care operations (TPO); *however*, the practice is not required to agree to your requested restrictions but if it does, it is bound by those restrictions.

13. You have the right to review the six page Notice of Privacy Practices (located at Reception) at any time. You have the right to obtain a personal copy of the Notice of Privacy Practices.

By signing this form, I am consenting to Dr. Freeman's use and disclosure of my PHI to carry out TPO. I may revoke this consent at any time by submitting a request in writing to the Office Manager/Privacy Office. If I do not sign this consent, Dr. Freeman may decline to provide treatment to me. (The sole purpose of this consent is to protect your right to privacy according to the Health Insurance Portability and Accountability Act which passed in August, 1996 and became effective April 14, 2003).

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Relationship to Patient Patient's Name if different than above

_____Date