Patient Name_____ Chart #_____ Date_____

Patient Financial Agreement

1. I understand that the services or procedures rendered by Dr. Joe Niamtu are completely cosmetic in nature and not covered by insurance. No claims will be filed today or in the future for any cosmetic procedures. For your convenience, we offer several payment options including: cash, check, debit card and credit card (MasterCard, VISA, Discover and American Express). For those patients who qualify, third party financing is also available through CareCredit. By endorsing this policy, you authorize us to make any necessary credit investigation, including employment verification.

2. Non-Refundable Consultation Fee for Virginia Patients- We require a non-refundable $75 deposit to reserve your appointment. This deposit will be held on your account and applied toward any products or services in the office to be used within one year. If the patient cancels their appointment within 7 days of the scheduled appointment or does not show for the appointment, the fee will be applied to the account and will not be eligible for use toward products or services.

3. Same Day Cosmetic Procedures- Full payment is due on the day that services are rendered.

4. Surgery Center Procedures- A $500.00 non-refundable deposit is required to secure a surgery date. This deposit will be applied to your surgical fees unless the surgery is cancelled or rescheduled within 30 days of the scheduled surgery date. The remaining balance is due two weeks before the procedure.

5. Skin Care and Cosmetic Products - all skin care and cosmetic product sales are final and non-refundable.

6. Out of State Patients- Due the increased time required for consultations with out of town patients, a $175 consultation fee is due to reserve your appointment. This deposit will be held on your account and applied toward any products or services in the office to be used within one year. If the patient cancels their appointment within 7 days of the scheduled appointment or does not show for the appointment, the fee will be applied to the account and will not be eligible for use toward products or services. A $1500 non-refundable deposit is required to secure a surgery date. This deposit will be applied to your surgical fees unless the surgery is cancelled or rescheduled within 30 days of the scheduled surgery date. The remaining balance is due two weeks before the procedure.

7. Unpaid Balances – The office will assess a $50 fee on any returned checks. Charges reflected on billing statements are agreed to be correct and reasonable unless disputed in writing within thirty (30) days of the billing date. All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum. If your unpaid balance is turned over to an attorney or collection agency for collection, you agree to pay all costs associated with collection, including attorney fees equal to 33⅓% of the unpaid balance.

I have received and understand these policies and I agree to the terms listed above.

_____ _____
Signature (patient or responsible party) Date

Office use only:

Reviewed by (Employee Name): _____ Date: _____

Notice of Privacy Practices

REV: 7.15.14

Patient Consent Form and Authorization for other Uses of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based upon your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- Although we do not participate in fundraising activities, patients do have the right to opt out of fundraising communications.
- The patient may restrict disclosures to their Health Plans when the patient has paid out of pocket and in full for services.
- It is the duty of the practice to notify the patient of a breach to their health care information unless there is a low probability that the information has been compromised.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.
-

Individuals who may receive information regarding the contents of my patient record:

_____; _____
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

_____; _____
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

_____; _____
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

_____ _____
Printed name - Patient or Guardian **Signature - Patient or Guardian**

Relationship to Patient: _____ **Date:** _____

Office use only:
Witness: _____ Date:_____ Chart # : _____