2022 CERTIFIED DERMATOLOGISTS CONSENT
FINANCIAL AGREEMENT, CONSENT TO TREATMENT
AND AUTHORIZATION FOR RELEASE OF INFORMATION

I understand this document is a Financial Agreement, Consent to Treatment, and Authorization for Release of Information for treatment at the offices of Certified Dermatologists ("Agreement"). The offices of "Certified Dermatologists" includes all facilities that operate as part of Anthony R Elias MD and Christine C Tam MD LLC and Dominic W Tam MD and Rose C W Tam MD Inc as well as facilities at which members of Anthony R Elias MD and Christine C Tam MD LLC and Dominic W Tam MD and Rose C W Tam MD Inc have received medical privileges. The agreements made and consents given by me in this form are valid for one year unless otherwise indicated in this document or revoked sooner by me. I understand that except as expressly limited in this document, I may revoke all or any part of the agreements and consents contained in this form at any time by submitting my revocation in writing to Certified Dermatologists.

1. **Financial Agreement**

a. **Financial Responsibility:** Subject to applicable law and the terms and conditions of any applicable contract between the members of Certified Dermatologists and a third-party payer (such as an insurance company, an employer-sponsored group health plan, or Medicare or another governmental health care program), and in consideration of all health care services rendered or about to be rendered to me or the patient named below, I agree to be financially responsible and obligated to pay Anthony R Elias MD and Christine C Tam MD LLC or Dominic W Tam MD and Rose C W Tam MD Inc for the total charges of the services received that are not paid under the "Assignment of Benefits" made below. I also agree to pay Anthony R Elias MD and Christine C Tam MD LLC or Dominic W Tam MD and Rose C W Tam MD Inc, at the time of service, any applicable actual or estimated co-payment or co-insurance for the health care services rendered during the visit(s) at Certified Dermatologists.

b. **Assignment of Benefits:** In consideration of all health care services rendered or about to be rendered to me or the patient named below, I hereby authorize payment from and assign to Anthony R Elias MD and Christine C Tam MD LLC or Dominic W Tam MD and Rose C W Tam MD Inc all rights, title and interest in and to any benefits or amounts due from any and all insurance policies, employer-sponsored group health plans, and/or any other responsible private or governmental third-party payers in an amount not to exceed Certified Dermatologists' regular and customary charges for the health care services rendered. I consent to any request for review or appeal by Anthony R Elias MD and Christine C Tam MD LLC or Dominic W Tam MD and Rose C W Tam MD Inc to challenge a determination of benefits made by any private or governmental third-party payer. Except as otherwise required by law, I assume responsibility for determining in advance whether the services provided to me, or the patient named below, are covered by any private or governmental third-party payer.

c. **Claims Submission Certifications:** I understand the information in this document or otherwise given by me to Certified Dermatologists will be used in submitting claims for payment for services rendered to me or the patient named below, and I certify that such information is correct. I authorize a

copy of this document to be used in place of the original, and the use of “signature on file” on all claims submissions. I agree to notify Certified Dermatologists if any of the information I have provided in this document changes or is no longer accurate and understand that I am responsible for notifying Certified Dermatologists of the new or corrected information. I understand that I am responsible for notifying Certified Dermatologists of any pre-certifications or referrals required by my health plans or the health plans of the patient named below. In the event any account becomes delinquent and collection activity is required to collect payment, I agree to pay all reasonable attorney fees and collection agency costs and/or fees associated with the collection of any unpaid balance.

d. **Signature:** I understand that by signing this document, I become liable for all amounts incurred for patient care and other related services rendered by Anthony R Elias MD and Christine C Tam MD LLC or Dominic W Tam MD and Rose C W Tam MD Inc.

2. Notice for Medicare Patients

a. **Patient’s certification, authorization to release information and payment request:** I certify that the information provided by me, or the patient named below, in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me or the patient named below to release to the Social Security Administration, the Center for Medicare and Medicaid Services, and/or its intermediaries or carriers any information needed to adjudicate or address any Medicare claim relating to the provision of health care items or services. Similarly, I authorize the Social Security Administration, the Center for Medicare and Medicaid Services, and/or its intermediaries or carriers to release information about me or the patient named below in order to establish Medicare entitlement or to adjudicate or address any Medicare claim relating to the provision of health care items or services. I request that payments of authorized benefits be made to me or on my behalf or on behalf of the patient named below. I assign the benefits payable for practitioner services to the practitioner or organization furnishing the services, or authorize such practitioner or organization to submit a claim to Medicare for payment to me. I understand that if, under Medicare program guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment as set out above under the “Financial Agreement”.

3. Consent to Treatment

a. **Consent to Treatment:** I hereby consent to and authorize the administration and performance of medical treatment and/or diagnostic testing by Certified Dermatologists as considered necessary for my condition, or the condition of the patient named below, as directed by the physician, health care practitioner, associated, assistants, or designees as may be needed to carry out my treatment and/or testing or the treatment and/or testing of the patient named below. I understand that interns, residents, fellows, nurses, medical students, medical assistants, and other health personnel in training may participate with or assist my physician(s) , or the physician(s) of the patient named below, in the performance of medical, surgical, or diagnostic procedures/treatment that the physician(s) consider necessary.

b. **Blood Tests and Samples:** I authorize Certified Dermatologists to order blood samples for testing

of communicable or sexually transmitted diseases including, but not limited to HIV and Hepatitis, if a physician orders the test for diagnostic purposes for me or the patient named below or in the event a health care worker has been exposed to my blood or bodily fluids or the blood or bodily fluids of the patient named below. I authorize Certified Dermatologists and my, or the below named patient's, physician, dentist, surgeon, or podiatrist to have the results of these tests. Except when an HIV test is performed in a medical emergency and the test results are medically necessary to avoid or minimize an immediate danger to me, or the patient named below, or others, I understand that in Ohio, I, or the patient named below, have the right to an anonymous HIV test.

c. Additional Consents to Treatment for Ambulatory Surgical and other Procedures:

1. For myself or for the patient named below, I voluntarily consent to care as a patient at Certified Dermatologists and authorize the administration and performance of all medical treatment and procedures, the use and administration of any pharmaceutical products including therapeutic agents, anesthesia and/or anesthetic agents and the use of any medically accepted diagnostic procedures that may be prescribed and deemed appropriate and necessary by the attending physician or associates or assistants of his or her choice.
2. I further authorize Certified Dermatologists personnel to take samples, specimens, and cultures, to perform medically necessary laboratory and diagnostic tests and procedures and dispose of such in the customary fashion, and to take such precautions as necessary for my treatment and safety, or the treatment and safety of the patient named below, and the safety of others.
3. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the outcome of the medical or surgical treatment or examination to be rendered at Certified Dermatologists. I understand that there may be some risks from some medicines if I am, or the below named patient is, pregnant. I know that it is my responsibility to discuss possible pregnancy with the physicians before examination or treatment.
4. I understand that if I, or the patient named below, leave the Certified Dermatologists facility against the advice of any physician or refuse treatment or medication, Anthony R Elias MD and Christine C Tam MD LLC and Dominic W Tam MD and Rose C W Tam MD Inc are not responsible for any ill effect the decision may cause.

d. **Right to Revoke:** I understand that I may revoke my consent at any time and that this decision is mine alone. This consent shall remain in full force and effect until revoked in writing.

4. <u>Medical Records/Release of Information</u>

a. **Release of Records:** I authorize the release of medical records information, and I specifically authorize the release of information concerning treatment relating to HIV testing, AIDS or AIDS related condition, treatment of mental health or psychiatric condition(s), and/or treatment of alcoholism or drug abuse to insurance carriers or their associates, third-party payers or their representatives, the Social Security

Administration or other authorized governmental agency, and/or review organizations as deemed necessary to establish or verify my benefits entitlement, or that of the patient named below, for Certified Dermatologists or physician claims for services rendered and to process payment claims and obtain reimbursement from such third-party payers for the health services provided. I also authorize my records, or the records of the patient named below, to be released to state, federal, or other surveyors for accreditation and/or regulatory licensing purposes and to others engaged in health care operations such as training, credentialing, quality improvement, legal compliance, contracting, and administration. I also authorize release of my medical record information, or that of the patient named below, as required or permitted by law. For example, cases of HIV, tuberculosis, viral meningitis, and other communicable diseases may require mandatory reporting to organizations such as health departments or the Centers for Disease Control and Prevention. The authorization provided in this section will expire one year after the conclusion of my, or the below named patient's, health care services. I am aware that I can revoke, in writing, this authorization at any time except to the extent that action has been taken in reliance thereon.

b. **Release of Electronic Medical Records for Treatment Purposes:** I authorize the electronic release of medical records information, and I specifically authorize the release of all information concerning treatment relating to HIV testing, AIDS or AIDS related condition, and/or treatment of mental health or psychiatric condition(s), to other health care providers who utilize an electronic medical record system compatible with the Certified Dermatologists records system only for the purposes of providing treatment to me, or the patient named below. The authorization provided in this section will expire one year after the date of discharge. I am aware that I can revoke, in writing, this authorization at any time except to the extent that action has been taken in reliance thereon. I understand that if I refuse or revoke this authorization Cerfified Dermatologists will not deny any treatment to me or the patient named below.

c. **Release of Drug and Alcohol Related Information:** I understand that under Federal and Ohio law the disclosure of medical records related to the diagnosis, prognosis, or treatment of alcoholism, alcohol abuse, or drug abuse require a separate written authorization that includes the following: Name of the program making the disclosure; name of the individual or the organization to receive the disclosure; name of the patient; the purpose of the disclosure; the type and amount of information to be disclosed; the signature of the patient or person authorized to give consent; the date the patient or other authorized person signed the form; a statement that the consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it; and the date, event or condition upon which the consent will expire, unless revoked before that specified time. I further understand that this information will not be released without the separate written authorization described above.

d. **Photography:**

1. I understand and agree that my image, or the image of the patient named below, will be photographed for purposes of identification, assisting in my care, and assisting in certain

health care operations of Certified Dermatologists, such as performance improvement programs.

2. I consent to the photographing or videotaping of wound sites and/or appropriate portions of my body, or the body of the patient named below, for medical, scientific, or education purposes as may be requested by my, or the below named patient's, physician as long as my, or the below named patient's, identity is not disclosed. I understand that I may request cessation of recording and rescind consent for use up until a reasonable time before use.

e. **Electronic Prescribing:** I hereby consent to and authorize Certified Dermatologists and its affiliates, including physicians or other prescribers providing treatment to me or the patient named below at a Certified Dermatologists facility, to access or input prescription benefit or medication history for me, or the patient named below, on the Surescripts Network or other electronic prescription services.

f. **Electronic Medical Records:** I understand that the facility where I am submitting this document is part of Certified Dermatologists or is a facility at which a member of Certified Dermatologists has privileges. I understand that the medical records kept by Certified Dermatologists are maintained in an electronic medical record system that is utilized by all of Certified Dermatologists and accessible from all Certified Dermatologists locations. I understand that medical records concerning my, or the below named patient's, conditions and treatment may be accessed at locations within Certified Dermatologists other than the facility at which treatment is being provided. I authorize the release of information from the medical record to members of the medical staff, its allied health professionals, employees, other facilities and organizations of Certified Dermatologists and its agents as well as to accrediting and licensing/regulatory entities who have agreed to keep such information confidential, for the purpose of continuity of care, reviewing or auditing the performance of this facility, its medical staff, its allied health professionals, its employees, and/or its agents or otherwise assisting this facility in either its administration or the rendering of patient care.

g. **Contact Information:** I have voluntarily given my cell phone, home phone, and/or other contact number so that I may be contacted. I authorize Certified Dermatologists or its agents to contact me at any telephone number associated with my account, including wireless telephone numbers or other numbers that may result in a charge to me, whether provided in the past, present, or future. I also authorize contacts and messages by automated dialers and other mechanical devices that may or may not leave messages regarding my account, such as for purposes of collection services and appointment reminders.

h. **NOTICE:** Medical records of Certified Dermatologists are kept on file for the period of time designated in Certified Dermatologists' document retention policy and then destroyed. I understand that every patient or his or her legal representative has a right to inspect and obtain a copy of his or her medical record. There will be a charge for this service.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THESE DOCUMENTS:

- **2022 CERTIFIED DERMATOLOGISTS CONSENT, FINANCIAL AGREEMENT, CONSENT TO TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION**
- **CERTIFIED DERMATOLOGISTS NOTICE OF PRIVACY PRACTICES**

Adult Patient, Parent, Guardian, or Power of Attorney Agent:

Signature:____

Printed Name:____

Date:________________________

Printed Name of Patient (if different from above, i.e. child or Power of Attorney Principal):

____