

Steven L. Mackey, M.D.

FELLOW AMERICAN ACADEMY OF DERMATOLOGY

3368 HIGHWAY 280, SUITE 208  
ALEXANDER CITY, ALABAMA 35010  
Telephone (256) 409-2159

822 NORTH DEAN ROAD, SUITE 300  
AUBURN, ALABAMA 36830  
Telephone (334) 501-7001

1722 PINE STREET, SUITE 400  
MONTGOMERY, ALABAMA 36106  
Telephone (334) 263-1400

**We are concerned about the cost of your health care and want to address some current issues related to the cost of medical services. Please take a moment to review this information. Thank you.**

Considerable care has been taken in setting our fees. Every effort has been made to insure that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

**Please understand that our service agreement is with YOU and NOT your insurance company.** Just as you have chosen your insurance coverage, you are ultimately responsible for payment for the service you receive. Any claims filed by us are done as a courtesy. If no payment is received from the insurance company within 45 days, payment will be due from the patient. If after you have contacted your insurance company, further assistance is required from our office, we will be glad to help. We thank you for your cooperation in this manner.

**Medicare:**

We are Participating Providers and accept the Medicare approved amount as the total charge for Medicare covered patients. Please remember, however, that Medicare alone does not cover the full approved amount. The 20% copayment, the deductible, and any necessary charges for non-covered services remain your responsibility. If you have Medigap (Medicare supplement) insurance to help with these charges, it will be filed with your Medicare.

**Other (Commercial) Insurance:**

Payment is due at the time of service for **copay, deductible, and non-covered services** for all office charges. These charges will be filed to your insurance.

**Charge Cards:**

For your convenience, we are pleased to accept Visa, Mastercard and American Express for your charges.

**Returned Checks and Delinquent Accounts:**

There will be a \$28.00 charge on all returned checks. If your account becomes delinquent and must be placed with a collection agency, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

*I have read and understand my financial responsibilities under this policy.*

Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone \_\_\_\_\_  
 O.K. to leave message with detailed information  
 Leave message with call back number only.

Work Telephone \_\_\_\_\_  
 O.K. to leave message with detailed information  
 Leave message with call back number only.

Written Communication  
 O.K. to mail to home address

Patient Representative (Someone other than the patient that we may give information to ex: spouse or parent of a minor child):  
 \_\_\_\_\_ (This line may be left blank if you do not wish for us to speak with anyone besides yourself.)

Telephone Number if different from Patient: ( ) \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Date of Birth

### For Office Use Only

#### Record of Disclosures

Date	Disclosed to: Name & Address	Description of PHI Disclosed	Person Disclosing	Method of Disclosure M,P,F,OT

M-Mail P-Telephone F-Fax OT-Other

Alexander City Dermatology, P.C.  
DBA Dr. Steven L. Mackey  
822 North Dean Road, Suite 300  
Auburn, Alabama  
36830

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Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Alexander City Dermatology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Alexander City Dermatology. I understand that diagnosis or treatment of me by Dr. Steven Mackey may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Alexander City Dermatology is not required to agree to the restrictions that I may request. However, if Alexander City Dermatology agrees to a restriction that I request, the restriction is binding on Alexander City Dermatology and Dr. Steven L Mackey.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Steven L. Mackey or Alexander City Dermatology has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Alexander City Dermatology's Notice of Privacy Practices prior to signing this document. The Alexander City Dermatology's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Alexander City Dermatology. The Notice of Privacy Practices for Alexander City Dermatology is also provided at 822 North Dean Road, Suite 300. This Notice of Privacy Practices also describes my rights and the Alexander City Dermatology's duties with respect to my protected health information.

Alexander City Dermatology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

