dermatology
& laser center
of chapel hill

58 Chapelton Court, Suite 120
Chapel Hill, NC 27516
Phone (919) 942-2922 Fax (919) 903-9183
contact@dlcofchapelhill.com

Financial Policy and Office Protocols

Patient Registration

New patients must complete the Registration process prior to receiving medical care. New Patients receive a Patient Registration link for MyPatientVisit, (MPV) our secure patient portal. Please create an account to complete your forms. Forms do not need to be printed from the portal. If you need to complete your forms in our office, please arrive 15-20 minutes prior to your scheduled appointment time.

Telehealth

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through secure electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. DLC uses Klara as our telehealth platform. Electronic communication cannot be used for emergencies or time-sensitive matters.

Appointments

We send text and email reminders 3 days prior to the appointment. We require a 48-hour cancellation notice. **A $105.00 fee is charged for cancelled appointments with less than a 48-hour notice unless for an emergency.**
Each time a patient misses an appointment without providing 48-hour notification ("no-shows"), another patient is prevented from receiving care. After two no-show appointments, we collect $105 in advance to schedule future appointments. After three (3) no shows within a (1) year period, we may discharge the patient from our practice.

Please be aware that Monday appointments must be cancelled by noon on the previous Friday. For canceled/missed/and/or rescheduled Accutane follow-up appointments, please know that we may not be able to accommodate your appointment in a timely manner.

Appointment length is determined by the health issues that the patient tells our schedulers. Lengthy delays result when patients request additional time to address issues other than those originally scheduled. Please be considerate of those waiting.

Late Arrivals. If running more than 15 minutes late, we may need to reschedule your appointment or shorten your numb time. We will try to accommodate as we all run late sometimes.

DLC Insurance Contracts

Your insurance coverage is a contract between you and the insurance company. We are in-network providers with Medicare, Cigna, United Health Care and some Blue Cross Blue Shield plans*. We collect non-covered charges, copay, co-insurance and/or deductible amounts at the time of service. ****We do not accept BCBS Blue Local/Home, BCBS Blue Value, Cigna SureFit/ IFP nor Aetna insurance plans.*** Payment is due in full at the time of the service. We accept cash, check, Visa, Mastercard, Discover, and American Express. There is a $30.00 Returned Check Fee. **The cosmetic consultation fee is $105.00.**

Referrals

If your insurance plan requires that your visit at DLC has a prior authorization or a referral, please obtain this from your referring Primary Care Provider. You are responsible for obtaining your insurance prior authorizations. If the DLC provider orders a test or referral to another specialist, please allow 5 days for our clinical staff to process your referral.

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Medication Refills

Please allow up to 48 hours for prescription requests. Whenever possible, we try to accommodate requests the same day you call. Please submit your request via the patient portal MPV or KLARA, our secure messaging platforms, as this can result in a quicker response time. Patients not seen at our office in at least one year are required to schedule an appointment before we may authorize refills.

Lab and Test Results

Your care may require us to send a specimen or blood work to an outside laboratory. The outside lab will bill you or your insurance company directly. **You will receive a separate bill from the labs: Tripoint Diagnostics, Dermtech and/or LabCorp.** Some test and lab results can take up to 10-14 days. We will call you if your results require further treatment or evaluation. We communicate normal results on the MyPatientVisit patient portal or the Klara patient portal.

Medical Records

Medical record requests require 3 days notice and are subject to a fee. A medical records release form must be on file before records are released to an outside party. Records may be released to another provider free of charge. Your records may be released to you free of charge.

No Recording Policy. DLC prohibits the use of any recording devices in the waiting area or in the exam rooms. Any unauthorized recording or photography may result in dismissal from our practice.

Patient Responsibilities. As a patient, it is your responsibility to: truthfully complete all required chart forms, arrive for your appointment on time and prepared; follow the prescribed treatment plan; have dependable transportation to and from our office; have adult supervision post-procedure when/if required by our providers; obtain insurance referrals; accept financial responsibility for services not covered by your insurance; pay for services at the time rendered; and treat our staff and other patients respectfully. DLC has a zero-tolerance policy toward unacceptable conduct such as violence, disparaging language, and harassment.

I agree that I have completed all information truthfully and have read and understand my patient responsibilities. Failure to comply with DLC's Financial Policy and Office Protocols may result in dismissal from our practice.

Patient Signature:_____ Date :_____
Relationship to patient (if not self) :_____

Privacy Notice Agreement: I understand that the Dermatology & Laser Center of Chapel Hill, PLLC, may use my health information for treatment, payment, and health care operations. I have been shown a copy of the practice's Notice of Privacy Practices (NPP) that describes how my information may be used and disclosed. I understand that the Practice has the right to change this notice at any time. I may obtain a current copy of the NPP by contacting the practice at (919) 942-2922.

Patient Signature:_____ Date :_____
Relationship to patient (if not self) :_____

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SECURE COMMUNICATIONS INFORMED CONSENT

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By signing the form below, I acknowledge and accept the following:

- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- I understand that telehealth billing information is collected in the same manner as a regular office visit and that I am financial responsible for rendered services.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
    - *Electronic systems that are accessed by employers, friends, or other are not secure and should be avoided. It is important for me to use a secure network.*
    - *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures*
- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes the right to access my own medical records (and copies of medical records).
- I understand that Skype, Facetime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations – including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during the telehealth visit.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.
- I certify that I have read and understand this agreement.

Patient name: _____ Patient/ Legal Representative Signature _____

Legal Representative name and Relationship to patient_____ Date:_____

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