WELLESLEY DERMATOLOGY CARE

PATIENT CONSENT FORM

Patient Name: ______________________ **D.O.B.:** ____________ **Date:** ____________

I have read and agree to the:
Acknowledgement of Receipt of Privacy Policies** and **Consent to Disclose Health Care Information
NPP Last Revised: June 29, 2026

SIGN HERE

I have read and agree to the:
Insurance Waiver due to Lack of Valid Referral

SIGN HERE

I have read and agree to the:
Consent to Treat and Financial Responsibility

SIGN HERE

I have read and agree to the:
Credit Card Policy

SIGN HERE

CANCELLATION POLICY: *A cancellation fee will be charged for any missed appointment if 24 hours notice is not given, unless acceptable documentation of an emergency is provided.*

Patient / Guardian Initial: ____________

I would like to receive email from Wellesley Dermatology Care at the following emails address: ______________________ @ ____________

I AM MOST INTERESTED IN *(select one)*: ☐ Medical ☐ Cosmetic ☐ Healthy Skin ☐ All of the Above

If signed by a Parent / Guardian, please list name and relationship: ______________________

PATIENT CONSENT FORM

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES AND CONSENT TO DISCLOSE HEALTH INFORMATION

By my signature, I hereby acknowledge that I have received a copy of the Notice of Privacy Policies for the Practice. I hereby consent to the Practice's disclosure of my medical information for treatment, billing, and health care operations (collectively TBO). Unless I instruct otherwise in writing, I also consent to the Practice's disclosure of my medical information on my home answering machine/voicemail or cell phone voicemail and to my spouse/partner, children, and other family members.

I understand that my medical record contains or may contain in the future information classified as highly confidential. By my signature below, I specifically consent to the disclosure of such information for TBO purposes, including: information about genetic testing; information about venereal disease(s); information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor, or other allied mental health professional or human service professional; information about family planning services, abortion consent form(s) or mammography records; if I am an emancipated minor, information about my treatment and diagnosis (except to my parents); and information about research involving controlled substances.

If I do not wish such highly confidential information to be disclosed, I will specify that in writing to the Privacy Officer at the Practice. I will need to sign separately for the release of information about HIV/AIDS status or treatment for substance abuse (alcohol or drug).

INSURANCE WAIVER DUE TO LACK OF VALID REFERRAL

I understand that I am financially responsible for any services not covered or allowed, but not paid due to the terms of my insurance coverage. I understand that it is my responsibility to comply with the guidelines set by my insurance company.

I understand that all co-payments, deductibles, and non-covered charges are due at the time of service.

I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approval for medical visits. If applicable, I understand that I have an obligation to obtain a referral for specialist services from my primary care physician (PCP) prior to having services rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.

If uninsured, full payment for all services is due on the date of service. I understand that future appointments may be contingent upon having met my financial obligations within the office, or having made appropriate arrangements with Wellesley Dermatology Care. This document serves as notification that in the event of insurance denial(s) of the claim(s) filed on your behalf, you will be responsible for any/all balances due.

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

By my signature, I voluntarily give my informed consent for myself and/or my child to be examined and treated by the physicians and staff at Wellesley Dermatology Care, ("the Practice"), including medical evaluation, treatment, and related procedures that are necessary in the judgment of the Practice. I acknowledge that no guarantees have been made to me concerning the results of outcomes of evaluations, tests, treatments, or procedures. I understand that the Practice may find that additional evaluations, tests, or procedures are necessary for my care. I understand that I am ultimately responsible for following the instructions of the Practice and for having any recommended evaluations, testing, or procedures performed. I understand that by signing this form, I am authorizing the Practice to treat me for as long as I seek care from the Practice, or until I withdraw my consent in writing.

By my signature below, I hereby assign to the Practice the right to receive payment of benefits for any service rendered to me by the Practice. I understand that I am financially responsible to the Practice for services I receive which are not covered under my health insurance. I hereby certify that the information given by me in applying for payment under any State or Federal health care program (including but not limited to Medicare and Medicaid) or submitted by me to my insurance carrier(s) is complete, accurate, and correct.

CREDIT CARD AUTHORIZATION AND PAYMENT POLICY

It is the policy of this office that you provide a valid credit, debit, or health-benefit card to be securely stored on file. Your payment information will be protected using reasonable administrative, technical, and physical safeguards in accordance with applicable law. We do not retain your card verification code after authorization. By signing below, you authorize this office to use the card on file for your final patient-responsibility balance and for any other charges you separately authorize, after claims have been submitted to and processed by your insurer(s), except for amounts due at the time of service, and only to the extent permitted by applicable federal and Massachusetts law.

Your stored card may be used only for amounts you are legally responsible for, including applicable copayments, coinsurance, deductibles, and other patient-responsibility amounts for services rendered, after insurance adjudication, unless payment is required at the time of service. We will not charge your card for amounts that are prohibited by law, prohibited by payer contract, still pending with an insurer, or subject to a timely good-faith dispute.

Before we bill your credit card, we will send two billing notices to your mailing address, email, or Patient Gateway account on file, allowing you the opportunity to question the charge and to pay. You are responsible for keeping your mailing address, email address, and Patient Gateway account information current. If you timely notify us that you dispute a charge in good faith, we will suspend any card-on-file charge for that disputed amount while we review it. If you do not pay the balance or contact us within 30 days after the **second** billing notice is sent, you authorize us to charge the card on file for the undisputed amount due. You may revoke this authorization at any time by written notice for future charges, after we have had a reasonable opportunity to process your revocation, but you remain responsible for all amounts lawfully owed for services already rendered. We will provide a receipt for any charge made to the card on file, if desired.

By signing, you represent that you are the cardholder or an authorized user of the card provided and that you authorize its storage and use as described in this policy.

CANCELLATION POLICY

All patients are required to give at least 24 hours advanced notice when cancelling an appointment. A missed appointment is defined as any appointment for which a patient does not arrive for as scheduled (“no show”), or is cancelled without a minimum of 24 hours notice (“late cancellation”). Failure to give 24 hours notice (“late cancellation”) or giving no notice at all (“no show”) will result in a fee. Except where prohibited by MassHealth/Medicaid, One Care, payer contract, or other applicable law, a cancellation fee of $100 will be charged for any missed appointment without a minimum of 24 hours notice. We may waive the fee for emergencies or circumstances outside the patient’s control. No shows and late cancellations severely limit our provider’s ability to care for patients. If you “no show” an appointment or cancel without a minimum of 24 hours notice, that slot is not available for other patient’s access and we need to find you another slot in our provider’s busy schedule. Future appointments may be limited until the balance is resolved, except where prohibited by law.

NOTE: Please read all pages carefully. You will sign to acknowledge receipt of each policy.