CLEAVER DERMATOLOGY · PO BOX 7545 · 1316 COUNTRY CLUB DRIVE, KIRKSVILLE, MO 63501 · 660-627-7546

Consent for Minor Surgery, Biopsy & Cryosurgery

During your visit, the dermatologist may need to perform cryosurgery or a skin biopsy to treat or evaluate your skin condition. Please review and sign the consent form below. You will be given ample time to discuss the procedure if the doctor determines cryosurgery or a biopsy is necessary. This will serve as a standing consent for this and any and all future treatments, however verbal consent will always be obtained prior to any treatment.

PURPOSE:
A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

Cryosurgery is the use of liquid nitrogen to freeze the skin lesions that respond well to sub-zero temperatures. The process freezes potential skin cancers known as actinic keratosis or solar keratosis. The treatment is also used to freeze the virus infections that cause many common warts.

PROPOSED TREATMENT:
I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician(such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing.
A pathologist will examine the tissue obtained in this biopsy procedure. I understand I may receive a separate bill from the pathologist or laboratory for this microscopic examination.
Complications of applying liquid nitrogen to the skin may include:

- Irritation
- Redness
- Temporary discomfort
- Blistering
- Infection
- Permanent loss of pigmentation

After the lesion has been treated, most patients develop a blister or scab that lasts for 1-2 weeks.

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY:
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. The collected information will be stored in my electronic medical record and becomes a part of my personal medical record. It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

OTHER ACKNOWLEDGEMENT DISCLOSURE:
I am able to read and understand English. I understand that I will have the opportunity to discuss my procedure with the physician or other professional who is to perform the procedure and have all of my questions answered to my satisfaction.

PHOTOGRAPHIC CONSENT:
I AUTHORIZED AND CONSENT TO THE TAKING OF A SERIES OF PHOTOGRAPHS OF THE SURGICAL AREAS FOR THE USE OF DR. CLEAVER FOR DOCUMENTATION OR EDUCATIONAL PURPOSES.

I agree to not photograph or record any part of my procedure during my visit today. This includes by camera, tablet, or cellular device.

_____ _____
Patient Name: Patient Date of Birth

_____ _____
Witness Signature Date Patient / Agent / Guardian Signature Date

Cleaver Dermatology and Skin Spa

Payment Policy Notification

Thank you for choosing Cleaver Dermatology for your skin care specialty needs. We are committed to providing you with high quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please review, ask any questions you may have, and sign in the space provided. A copy will be placed in your patient file and will be provided to you upon request.

- **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- **Co-payments and deductibles**. All co-payments must be paid at the time of service. When a surgery or other major procedure is scheduled we will contact your insurance company and an estimate will be prepared for you. Payments must be made the day of service based on your plan. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraudulent. Therefore, payment at time of service is mandatory. If there is a balance remaining on your account, you will be required to pay the balance prior to being seen again.

- **Non-covered and/or cosmetic services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

- **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

- **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- **Nonpayment.** Accounts should be paid upon receipt of bill. If payment has not been made within 90 days of receiving the bill, you will receive a letter stating that you have 10 days to pay your account in full. At this point, the account must be paid in full or a an ACH payment plan must be put in place. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.
- **Payment Plans.** A billing specialist will work with you to implement the ACH payment plan when warranted. Balances of $1000 or less must be paid in no more than 12 months. Balances over $1000 may be paid over 24 months.
- **Travel Clinics**-It is very important to us that we serve patients in outlying communities. As such, our schedules are very heavy on these days and slots are valuable. If you miss any two appointments at one of our travel clinics, you will need to schedule at the Kirksville location only.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient Print Name Birthdate

_____ _____

Signature of Patient or Responsible Party Date