KDS Aesthetics
Policies, Consent to Treat, & HIPAA Acknowledgement

The following pages contain elaboration on the shortened forms (policies & procedures, consent to treat, and HIPAA acknowledgment) which are signed. If you have any questions, please let our office know.

Policies & Procedures

Office hours vary daily, clients are seen by appointment only. Please call 252-299-2910 to schedule.

For urgent concerns after typical office hours call: 252-962-8822 and ask to be connected to Dr. Szymanski

Thank you for selecting KDS Aesthetics, PLLC for you cosmetic and reconstructive needs. Our goal is to be your partner for your health care needs. We are committed to make available to you a personal physician provides for your cosmetic and reconstructive needs. We ask that you arrive 15 minutes prior to your appointment to allow staff time to complete and verify all your demographic information. Please have with you at check-in your insurance card(s), picture ID and your payment. If you do not have your insurance card(s) and we may not verify your coverage meaning you will be considered self-pay and services will be required to be paid at the time of the visit. If your insurance benefits state you have a deductible, copay, or coinsurance, you will be required to pay that at each appointment. Forms of payment we accept: CASH, CHECK, VISA, MASTERCARD and CARE CREDIT. If cash or check is not your payment form, a 3% (three) convenience fee may be charged. We will not accept postdated checks. We will not accept personal checks over the amount of $250.00. The receptionist does have the right to reschedule your appointment should you be unable to pay your copay and/or past due balance prior to you being seen or if you are late. Please be on time for your appointment. Our schedule may run over due to emergencies and unforeseen circumstances of each patient therefore we cannot guarantee each patient will be seen exactly at the given appointment time/arrival. A $15.00 charge will be incurred for payment refund requests. In the event that we receive a notice of Insufficient Funds for a personal check, we will charge an additional fee of $20 plus institutional charges. For billing statements, the biller will add a late fee if a second statement is sent. If payment is not received promptly, the credit card on file will be charged for the full amount of your delinquent bill. If I dispute any charge with my credit card company, I agree to pay my provider $200 chargeback fee and understand that my provider has the right to share necessary information about my procedure(s) or billing with my credit card company to resolve the dispute.

Cosmetic/non-medically necessary treatments: Payment may be required prior to performing treatment. A non-refundable scheduling fee may be required to book a surgery. Prior to surgery, 100% payment of the service(s) may be required.

Appointments: All patients are seen by appointment. If you are late for your appointment you may be rescheduled to the next available appointment. Appointment request after 14:00 may be scheduled the next business day. We strive to stay on schedule but due to emergencies and unforeseen circumstances we cannot guarantee each patient will be seen exactly at their scheduled appointment time. Appointment cards are offered when appointments are scheduled in the office, Patients are expected to keep up with their appointments regardless of appointment cards. Should you fail to call and cancel your appointment 24 business hours before your scheduled appointment time, we reserve the right to charge you the following missed appointment fees: $75.00 for a follow-up, $100.00 for a new patient, $200.00 for surgery and $150.00 missed appointment surcharge for evenings (after 5pm), weekends, or holidays. Please leave a message if you are unable to speak with someone should you need to cancel your appointment as this will date/time stamp your call. Patients who do not show for 2 or more appointments within a 12-month period are subject to be dismissed from the practice for non-compliance.

Late Fees:I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

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Credit Card on File Policy: We require that all patients have a credit card on file with our office. Credit cards on file will be used to hold your appointment time and to pay no show fees and account balances if you have an outstanding balance. Your credit card will be stored securely and for security reasons only the last four digits will be visible to our staff.

If we do not receive payment for the amount listed on your statement within 13 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

Consent to Treat

I consent to the treatment deemed necessary by the health care providers of KDS Aesthetics, PLLC upon my presentation to KDS Aesthetics for medical services.

I consent to the disclosure of any information to outside providers or agencies involved in my treatment as deemed necessary by my KDS Aesthetics provider or if such disclosures are required or permitted by law.

I consent for KDS Aesthetics to release any information and photographs required in the course of my examinations and treatment for the purposes of insurance and/or Medicare benefits payment and/or board examination process. Workman's compensation claim information may be leased to my employer.

I consent to assignment of payment directly to KDS Aesthetics of all medical benefits applicable and otherwise payable to me through insurance and any other source.

I agree in consideration of the services being rendered to me, I am hereby individually obligated to pay my account with KDS Aesthetics in accordance with its regular rates and terms. Also, I agree to these terms, if I am a Medicare patient and have been advised by the provider that I will be receiving a that Medicare may deny as "not reasonable and necessary", or a service which I have received an Advance Beneficiary Notice (ABN) from KDS Aesthetics.

I consent for KDS Aesthetics to act on my behalf in the collection of benefits from insurance carriers through whatever means deemed necessary and the endorsement of benefits checks made payable to me or KDS Aesthetics.

I consent to the disclosure of my medical information to people outside KDS Aesthetics involved in any clinic operations or if such disclosures are permitted by law.

I consent for KDS Aesthetics to communicate with me through any available media. Additionally, KDS Aesthetics may use or disclose information about me to notify or assist in notifying a family member, personal representative, or another person responsible for my care, of my location and general condition. KDS Aesthetics may also contact me with information about treatment alternatives or other health related benefits and services of interest to me.

I consent for KDS Aesthetics to view my external prescription history via RxHub Service – which will include history from other unaffiliated medical providers, insurance companies and pharmacy benefit managers.

Medicare Patients

I request that payment authorized Medicare benefits be made on my behalf by KDS Aesthetics, PLLC. For any services provided to me by providers of KDS Aesthetics PLLC to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of benefits payable for related services. This assignment will remain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

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HIPAA Compliance Patient Consent Short Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Protected health information and/or billing information may be used to confirm services rendered to patient if credit card company attempts to rescind patient's payment for services performed
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If YES, please name the members allowed:

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