Surgical Consultants of Dallas, L.L.C

Patient Policies and Signatory Pages

- I understand that my insurance policy is a contract between myself and the insurance company. Surgical Consultants of Dallas, LLC (SCD) is not a party to that contact.
- I am ultimately responsible for unpaid balances and non-covered services.
- I am responsible for informing the office of all changes to my information and insurance prior to my appointments. Insurance must be in force and verifiable at the time of treatment.
- If my insurance company requires a referral, it is my responsibility to obtain one prior to my appointment. If I do not obtain a referral, I agree to pay in full at the time of the appointment.
- I thereby assign all insurance benefits for services rendered, otherwise payable to me, directly to SCD from Medicare or private insurance.
- I authorize SCD to release medical information to my insurance company, its agents or third party for use in determining my benefits.
- If my account enters a delinquent status, I agree to pay all costs of collections, including attorney and court fees. If my account enters court collection status, I understand that I am no longer a patient of record.
- I understand that the fee for a returned check is $35.
- As a courtesy only, we will attempt to confirm your appointment prior to the date. SCD cannot guarantee a reminder call, email, or text. I understand that SCD charges a minimum fee of $30 for missed or cancelled appointments without 24 hours of notice. I agree to pay such fee.
- SCD will maintain patient records for a minimum of seven years following the last visit, barring any exceptions where we may pay required to keep them longer.
- I acknowledge that my rights to privacy for health information have been made available to me.
- I consent to allow the providers and their staff to examine and treat me.
- I grant permission to the providers and their staff to access my prescription history from external sources.
- I have read and understand the **Practice Policies** that are available to me.
- By signing below, I indicate my understanding and agreement with the policies listed above. This acceptance is good for one year. I will be provided a new acceptance letter if and when policies change.

Signature: _____ Date: _____

Name: _____

Surgical Consultants of Dallas, LLC
7777 Forest Lane Suite A-331
Dallas, TX 75230
(972) 566-7860
www.surgicalconsultantsofdallas.com

Notify of Privacy Practice

- I acknowledge that the Notice of Privacy Practice has been made available to me, which describes the way in which the practice may use and disclose my healthcare information for its treatment, payments, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notify of Privacy Practice.

  Initials: _____

Consent for Recording of Images

- The physician and/or staff may use photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or the practice health care operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or records will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or requested by law.

  I DO Consent (Initials): _____

  I DO NOT Consent (Initials): ____

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

- We want to stay connected with our patients. Patients in our practice may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time (see next page). The practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

  I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

  I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is**_____.