**OFFICE POLICIES**

**LATE POLICY:**

***OFFICE POLICY I* – All patients are asked to arrive 15 minutes prior to their appointment time. Late patients may be re-scheduled to another date or worked in around existing patient appointments.** New patients are asked to arrive 30 minutes prior to their scheduled appointment time if paperwork is not completed online. Our providers strive to be on time and are task oriented. They will do their best to address all patients’ needs in a timely fashion.

**CANCELATION AND NO SHOW POLICIES:**

***OFFICE POLICY II –*** Appointments must be canceled or re-scheduled at least **24 hours prior to the scheduled appointment date**. Failure to do so may result in a **$55.00** fee applied to the patient’s account. Missed appointments without prior notice to our office will result in a **$55.00 “NO SHOW FEE**” applied to the patient’s account. (In the event of an unexpected emergency in which you cannot make your appointment, we will consider waiving the fee that has been applied to the account.)

***OFFICE POLICY III*** – Failure to cancel or re-schedule a **cosmetic or surgical appointment (Botox, Excision, Laser, etc.)** at least 24 hours prior to the scheduled appointment date may result in a **$150.00** fee applied to the patient’s account. Missed cosmetic or procedure appointments without prior notice to our office will result in a **$150.00 “NO SHOW FEE”** applied to the patient’s account. (In the event of an unexpected emergency in which you cannot make your appointment, we will consider waiving the fee that has been applied to the account.)

**BOOKING FEE FOR COSMETIC APPOINTMENT POLICY:**

***OFFICE POLICY IV*** – A **NON-REFUNDABLE** booking fee is required before cosmetic procedure appointments can be finalized and placed on the schedule. The protocol for the deposit is as follows:

For **CoolSculpting**, **Ultherapy,** **Fractora,** and **Sculptra** appointments, a **$500** deposit is required for booking.

For all other cosmetic procedures (including but not limited to **Botox**, **Dysport**, **Xeomin**, **Juvederm**, **Radiesse**, **Voluma**, **Belotero**, **Restylane**, **IPL**, **microneedling**, **Forma**, **chemical peels**) a **$100** dollar deposit fee is required for booking.

All booking fees will be applied to procedures and the remaining balance due must be paid in full at the time of your visit.

**I have fully read and understand the office policies listed above. I agree to all terms and conditions. All questions and concerns regarding office policies have been addressed and answered to my satisfaction.**

Patient Name (Print)

Patient or Guardian Signature

 Relationship

Date MR# Updated: 4/2018 (OFFICE USE ONLY)

**Notice of Privacy Practices and Patient Consent**

**For Use and Disclosure of Protected Health Information**

**I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information.**

I understand that Braun Dermatology & Skin Cancer Center P.C.. may use or disclose my protected health information for treatment, payment, or health care operations—which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other use or disclosure of this information without my authorization.

Braun Dermatology & Skin Cancer Center P.C. has a detailed document called the **‘Notice of Privacy Practices’.** It contains a more complete description of my rights to privacy and how the office may use and disclose protected health information.

I understand that I have the right to read the ‘Notice’ before signing this agreement. If I ask, Braun Dermatology & Skin Cancer Center P.C. will provide me with the most current Notice of Privacy Practices.

**My signature below indicates that I have been given the chance to review the Notice of Privacy Practices and that I agree to allow Braun Dermatology & Skin Cancer Center P.C. to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Braun Dermatology & Skin Cancer Center P.C. has taken action relying on this consent.**

Patient Name (please print) Date

Signature (Patient or Legal Custodian / Authorized Representative) Relationship (if signed by another party)

My health information may be discussed with:

 Name/Relationship

My health information may NOT be discussed with:

 Name/Relationship

MR#\_\_\_\_\_\_\_\_\_ (OFFICE USE ONLY)