

As a patient and active participant in your health care, we want you to know your rights.

You have the right to:

- Health care that respects your cultural, psychosocial, and personal values and beliefs.
 - Know that your records and communications are confidential to the extent provided by law.
 - Expect privacy during medical treatment and care.
 - Have all reasonable requests responded to promptly and adequately.
 - Inspect your medical record and receive a copy of it. If you would like a copy, you may be charged a fee.
 - Receive a copy of an itemized list of charges submitted by Island Dermatology to your insurer or another third party regarding your care.
 - Return retail products within 30 days of purchase for a credit or refund. All other refund requests will be handled on a case-by-case basis.
-
-

By taking an active role in your health care, you can help your caregivers meet your needs. That is why we ask that you share with us certain responsibilities.

We ask that you:

- Provide, to the best of your ability, accurate and complete information about your present condition, past illnesses, medications, and other matters related to your health.
- Follow the treatment plan developed with your provider. You should express any concerns about your ability to comply with a proposed course of treatment.
- Keep appointments or call 48 hours in advance when you are unable to do so. We would like the opportunity to offer your appointment to another patient.
 - You will be charged \$50.00 for each late cancellation (within 48 hrs) or no-show.
- Confirm your insurance benefits and financial responsibility prior to treatment.
 - We expect our patients to confirm network benefits and unmet deductibles.
 - There is an automatic processing fee of \$30.00 for returned checks.

Patient Rights & Responsibilities

Island Dermatology

- If your account is in collections, we will require a credit card to schedule your appointments.

I have read and understand my rights and responsibilities as a patient at Island Dermatology.

Signature _____

Date _____

Patient Name _____

Rev. 8/10/09