

MID-SOUTH DERMATOLOGY & SKIN CANCER CENTER
James E. Turner, M.D., Ph.D./Malika Tuli, M.D.

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial and privacy policies. If you have any questions, please inform a member of our front desk staff. Thank you.

CONSENT FOR TREATMENT

I desire to be seen and treated by James E. Turner, M.D., Ph.D., or Malika Tuli, M.D., (and/or their associates) and hereby give my consent for the clinic, its physicians and employees to see and treat me, as they deem necessary and appropriate for diagnosis and treatment. I authorize and consent for examinations, blood tests, laboratory procedures, injection of medications, local anesthesia, surgery, and other services, treatments or procedures rendered or performed at the clinic or ordered by its physicians or employees. I further understand that state law requires our practice report any communicable diseases to the health department.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) has been made available to me.

CONSENT FOR FINANCIAL RESPONSIBILITY

I request authorized benefits be made on my behalf to James E. Turner, M.D., Ph.D. or Malika Tuli, M.D. for any services furnished to me. I authorize any holder of medical information to release to the insurance carrier any information needed to determine these benefits payable for related services.

It is my responsibility to contact my insurance company and/or employer to verify that Dr. James Turner and/or Dr. Malika Tuli are participants in my insurance plan. If my insurance plan requires a referral, it is my responsibility to obtain the referral prior to being treated. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

I understand that I am financially responsible for all charges not payable by insurance, including annual deductible, copayment, coinsurance, and any non-covered/cosmetic services. If I am without verified health insurance or with a plan which Dr. Turner and Dr. Tuli do not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies any claim or pays my claim as "out-of-network", I am responsible for the balance. If it becomes necessary, I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for collection of this account. Our practice accepts cash, check, bank debit card, MasterCard, Visa, American Express or Discover. Each instance of a returned check is subject to a \$20 processing fee.

SIGNATURE OF PATIENT/GUARDIAN (Must be 18 years old or older to sign)

DATE: _____

OFFICE USE ONLY: EXPIRATION DATE: _____