LYNN M. SIKORSKI D.O., P.C.

Authorization and Agreements of Medical Treatment

Consent for examination: I understand that medical treatment may be necessary for the patient by Lynn M. Sikorski D.O., P.C., or her assistants. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not Lynn M. Sikorski D.O., P.C., or assistants. I hereby release my examiner from all responsibility in connection with the examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Lynn M. Sikorski D.O., P.C., or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of Lynn M. Sikorski D.O., P.C. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.
For patients less than 18 years old, parent or legal guardian must sign: I authorize for Lynn M. Sikorski D.O., P.C. and associates to treat my child and/or dependent.

Acknowledgement of Notice of Privacy Practices (HIPAA)

Lynn M. Sikorski D.O., P.C., in an effort to comply with HIPAA has a Notice of Privacy Practices available to all patients in the waiting area and with the receptionist. Each patient has been offered and/or received a copy.

Insurance Benefits and Financial Responsibility

Thank you for choosing us as you skin care provider. We are committed to you and the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we request you read and sign prior to your treatment.

1. All patients should complete the patient information forms prior to seeing the doctor.
2. Full payment is due at the time of service, unless we participate with your insurance company. We accept cash, check, and credit cards (Visa and MasterCard.)
3. All co-payments, deductibles, and non-covered services must be paid in full at the time of service.
4. Our office will submit claims to your insurance company as a service to you. We will not bill your insurance carrier unless you bring in all proper information and necessary claim forms. We will only accept assignment of benefits for insurance plans which we participate with. Any remaining balances after payment is received from your carrier, are your responsibility, not that of your insurance carrier.
5. Due to the specialized nature of our practice, and the specific needs of our patients, the practice provides some services that are not covered by insurance carriers. The staff will review these additional fees and services that are not typically paid by insurance policies. Patients with Medicare and some other plans must sign a waiver prior to receiving these additional services. A schedule of fees is available. It is important that you know what your insurance plan covers.
6. If you have HMO health insurance, it is your responsibility to get the required referral prior to your office visit. Failure to obtain a referral would result in you, the patient, being responsible for all costs incurred during your office visit.
7. If your insurance company requires laboratory specimens be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware of plan requirements. Please be advised that laboratory charges are completely separate from physician charges.
8. Minor patients: The adult accompanying a minor (or the parent/guardian) is responsible for full payment unless we participate with your insurance plan. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre authorized.
9. Returned check fee: Patients will be charged a $25.00 returned check fee for any check returned to us unpaid due to insufficient funds.
10. Patients may be charged a $20.00 fee for any scheduled appointment that is not cancelled at least 24 hours prior to the scheduled appointment time.
11. If you are experiencing financial difficulties, please discuss this with the doctor or biller. We will gladly work with you to make payment arrangements. Any account balance over 45 days will be referred to Congress Collections for collection. Please contact our billing department at (248) 338-6400 for questions regarding your bill, so that we may avoid collection action.

Please continue to read and sign the reverse side ►

LYNN M. SIKORSKI, D.O., P.C.

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Lynn M. Sikorski D.O., P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lynn M. Sikorski D.O., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Lynn M. Sikorski D.O., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lynn M. Sikorski D.O., P.C. at:

Privacy Officer
1900 S. Telegraph Road, Suite 100
Bloomfield Hills, Michigan 48302

With my consent, Lynn M. Sikorski D.O., P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and billing issues.

With my consent, Lynn M. Sikorski D.O., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent Lynn M. Sikorski D.O., P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Lynn M. Sikorski D.O., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Lynn M. Sikorski D.O., P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lynn M. Sikorski D.O., P.C. may decline to provide treatment to me.

I have read the above authorizations, acknowledgements, and policies. I understand them and agree to this as outlined.

Signature of Patient or Guardian____

Patient's Name (print)______________________ Guardian's Name (print)______________________

Relationship to Patient_______________ Date____________ Witness______________________

REV. 09/22/04