

Patient Consent for Use and Disclosure of Protected Health Information

I consent for Dermatology & Advanced Skin Care to disclose health information about me to carry out treatment, payment, and healthcare operations and to contact me regarding such matters as appointment reminders, insurance, and issues pertaining to clinical care. I authorize Dermatology & Advanced Skin Care to disclose appointment, medical, and financial information to:

Person authorized to receive your medical information (e.g. family member)

This authorization may be revoked in writing at any time.

Signature of Patient or Guardian

Date

Financial Policies

Concerning Insurance and Assignment of Benefits

I authorize this physician to apply for benefits on my behalf for covered services rendered. I certify the information I have reported with regard to my insurance is correct. If the information is found to be incorrect, I understand that I will be responsible for providing correct information or will be responsible for the incurred costs. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. A copy of this authorization may be used in place of the original. The authorization may be revoked by me or my insurance carrier at any time in writing.

I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Dermatology & Advanced Skin Care for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company, including but not limited to termination of coverage at time of visit, a non-covered benefit per my insurance plan, a cosmetic procedure, or lack of referral from my primary care physician. I also understand I am responsible for any collection agency fees (30-50% of the account balance) occurred from an overdue account.

Signature of Patient or Guardian

Date

Cancellation Policy for Appointments

If you are unable to keep your appointment, kindly provide a minimum of one business day notice to avoid being assessed a cancellation fee. This fee ranges from **\$25 to \$100** depending on the nature of the appointment. All cancellations for cosmetic and surgical procedures will be assessed \$100 if adequate notice is not provided. Appointments can be cancelled by calling our office 24-hours a day. Please sign below indicating that you are aware of this policy.

Signature of Patient or Guardian

Date

For Medicare Patients Only

I understand that in certain circumstances under Medicare law, Medicare may decide that services are not medically necessary or are cosmetic in nature. Since Medicare will deny payment for these services, I agree to be personally responsible for payment of these charges.

Signature of Patient or Guardian

Date