

PATIENT AGREEMENT FOR DERMATOLOGY ASSOCIATES

RELEASE OF INFORMATION: _____ (Your Initials)

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: _____ (Your Initials)

I have received and/or reviewed a copy of Dermatology Associates' Notice of Privacy Practices.

PAYMENT POLICY: _____ (Your Initials)

I certify that the information given for payment under government or private health insurance is correct. I understand I am financially responsible to the physician for all co-payments, deductibles and coinsurance. In the event I have no insurance or my insurance does not cover services provided to me, I am financially responsible for all services incurred. Physician reserves the right to impose reasonable financing and late charges as well as reasonable costs, attorney fees and expenses incurred in the collection of my account should it become delinquent.

I understand that Co-payments are due at the time of service. It is my responsibility to notify the receptionist upon arrival that a co-payment is due. A \$20.00 handling fee may be added to my statement in circumstances when I have not paid at the time of service. I understand that Non-sufficient funds (NSFs) for checks or credit card payments are subject to a \$25.00 handling fee for each submission.

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the balance after Medicare processes the claim. We do file with secondary/supplemental carriers, however, in the event that the secondary does not pay within 60 days, patients will be billed the balance.

Other: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic service. Patients who are covered by private, commercial plans in which our physicians are not providers are responsible for the entire unpaid balance left after payment from your insurance, regardless of the benefits and payment policies of your carrier.

CANCELATION POLICY: _____ (Your Initials)

I am aware that I will be charged for appointments missed or cancelled without 24 hour notice and that if I miss three appointments, I may be moved to walk-in status.

MESSAGES / FOLLOW-UP COMMUNICATIONS: _____ (Your Initials)

Do we have your permission to:

- | | | |
|---|------------------------------|-----------------------------|
| Leave a message on your answering machine at home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leave a message at your place of employment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discuss your medical condition with any member of your household? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If YES, whom: _____

Relationship: _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. PLEASE READ AND INITIAL THE FOLLOWING STATEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. _____ (Your Initials)

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", PLEASE READ AND INITIAL THE FOLLOWING STATEMENT

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ (Your Initials)

I certify the above information is correct to the best of my knowledge.

Name of Patient

Name of Responsible Party

Signature of Patient or Responsible Party

Date