ADVANCED DERMATOLOGY OFFICE POLICIES CONSENT FORM

Patient Name: _____ Patient Date of Birth: _____

The following is a review of our office policies. Please review and sign below. Some policies may not pertain to your treatment today, but may for future treatments / procedures.

- **PAYMENT OPTIONS:** (For procedures not covered by insurance, co-payments or balance dues): CASH, CHECK, VISA, MASTERCARD, DISCOVER, CARE CREDIT VISA, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. **All visit fees are due at time of service.**
- **Payment plans can be arranged with CareCredit Visa**. All balances due that do not get paid within the first 30 days are subject to finance charges which will accrue interest monthly. Please ask for details. You can apply for CareCredit in our office today.
- **The patient is responsible for all insurance deductibles, co-pays and services subject to plan limitation, and exclusions.**
- **Network Providers:** It is your responsibility to know if your provider is considered "In-network" by your insurance. Please call your insurance to verify and contact our Billing Office, if there are any questions regarding network eligibility. Some insurance companies change their policy administrator and this can be difficult to identify from your insurance card. We encourage you to confirm your In-network status with our office each time you receive a new copy of your insurance card.
- There is a $25 fee assessed if you fail to cancel or reschedule an appointment at least 24 hours prior or you no-show the appointment.

- 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. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments. We accept payment in the form of CASH, CHECK, VISA, MASTERCARD, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing.

- **Acknowledgement of Receipt of Privacy Practices:** I acknowledge the practice has provided me a copy of the Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

  If unable to reach me by phone: I give permission to the physicians or staff at Advanced Dermatology to release my test results or appointment information and discuss account/financial information with**:** (check all that apply)
  - o Spouse _____
  - o Child _____
  - o Parent _____
  - o Email _____
  - o Answering machine _____
  - o Other person _____

- **Consent to Treat:** I hereby authorize examination and treatment by Advanced Dermatology. I authorize release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration/CMS or intermediaries) and I assign payments (including Medigap benefits) for medical services to the physician(s). I understand that it is my responsibility to remit payments for charges not covered by my insurance company. I understand that it is my responsibility to see that all claims, pre-certifications and authorizations are completed by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent. I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential by our HIPAA policy.

Signature of Responsible Party: _____ Date: _____