SOUTHEAST DERMATOLOGY, PA

PRIVACY PRACTICE CONSENT AND RELEASE

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________________ ______________________

SIGNATURE of Patient or Personal Representative Date

______________________________________ ______________________

PRINTED NAME of Patient or Personal Representative If not self, description of Personal Representative's Authority

- I understand that by signing this form, I give permission for my doctor to collect payment due from my insurance for services performed. I understand medical records remain confidential as described in the Notice of Privacy Practices.

Emergency Contact Name & Number ____

I allow release of medical information to the following: (Please check all that apply)

☐ No one except myself ☐ Spouse: _________________________ ☐ Other: ___________________________

Financial Policy

Insurance

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of the visit.
2) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether prior authorization is required for a procedure, and what services are covered.

Payment

1) Self-pay patients are expected to pay for services in FULL at the time of the visit.
2) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
3) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
4) For scheduled appointments, prior balances must be paid prior to the visit.
5) We accept cash, checks, Visa, MasterCard, Discover, and American Express credit and debit.
6) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.

Fees

1) If you are not able to keep an appointment, we require a 24-hour notice. **There is a charge of $50.00 for missed office visit appointments, and $75.00 for missed surgery appointments.**
2) Co-payments are due at the time of service. A **$20.00 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of the next business day.
3) Any balance outstanding longer than 90 days will be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of **25% of the account balance**, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.
4) A **$30.00 fee** will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

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Signature of Patient (Parent/Guardian) Date