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 by my insurance for services performed. I understand medical records remain confidential as described in the Notice of Privacy Practices.

E-Mail Address: _____

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 co-insurance 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 a specialist, 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, American Express 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. Any over payments made by the patient will be automatically refunded to your credit card that is 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 subject to a fee of **25% of the account balance**. If account is turned over to collection agency, you agree to reimburse us for 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 attorney's 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.

_____ _____

Signature of Patient (Parent/Guardian) Date