Patient Acknowledgment of The Dermatology Specialists Office Policies

To be completed by **ALL PATIENTS. If the patient is under the age of 18, this form is to be filled out by his/her PARENT or GUARDIAN. Please read each item below and initial the space provided.**

A. Insurance Information / Co-payments and Deductibles

Payment is required for all services at the time they are rendered. If this office accepts my insurance, I understand that I am still responsible for paying any co-payment and deductibles that my insurance does not cover**. I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of dermatologic treatment rendered.** Checks returned for insufficient funds will be charged an additional $50 fee. Your signature below signifies your understanding and willingness to comply with this policy.

B. Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that any specialty treatments requiring pre-authorization are also ultimately the responsibility of the patient. **I understand that should I fail to present a valid referral, I may be responsible for any charges pursuant to specialist treatment.**

C. Insurance Cards

New patients or those patients who change insurance plans must provide a valid insurance card at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. **I understand that I am responsible for notifying the office of any changes to my insurance or contact information.**

D. Cancellation Policy

Should you be unable to keep your appointment, please contact our office. Failure to contact the office within 24 hours of your appointment will result in a $25.00 cancellation fee.

E. Statement of Financial Responsibilities

Cosmetic procedures are not covered by insurance and the cosmetic fee is the responsibility of the patient. I understand that any payments accepted today for cosmetic services are for any cosmetic services rendered today only and are not payments for future cosmetic procedures. As a courtesy to our patients, our office will bill private insurance for office visits and surgical procedures. Any surgery done for medically necessary reasons will be billed separately to your insurance. A statement will be sent our explaining the status of your account, and follow statements may reflect any remaining balance. Since the financial responsibility always resides with the patient, we want to keep you informed. For example: if your insurance has not paid within 30 days you may wish to call them directly to confirm payment within 60 days. After 60 days we may no longer pursue your insurance company, but you the patient, for the payment.

F. HIPAA Authorization

I request and authorize The Dermatology Specialists to discuss my medical condition with, confirm my appointments with, and provide my results to:

Name of Individual (please print) **Relationship to Patient**

_____ _____

This authorization has no expiration date. However, you have the right to revoke this authorization, at any time, by sending a letter to The Dermatology Specialists, 220 Front Street, New York, NY 10038. If you revoke this authorization, it will not be effective with respect to information that has already been shared. This authorization is purely voluntary—you cannot be required to sign it and your treatment and payment will not be affected if you do not give the authorization. Information provided under this authorization may be re-disclosed by the recipient, who is not subject to federal privacy standards.

G. HIPAA Acknowledgement

I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996. **By signing below, I, the patient or parent/guardian for those under the age of 18, indicate that I have read, understand, and accept this Patient Acknowledgment listed above and hereby comply with its nature.**

_____**Patient/Guardian Signature**