Associates in Dermatology, Inc.

Financial Agreement

I understand by signing this form that I am requesting that insurance payments for services rendered to be made directly to Associates in Dermatology, Inc. and that I am authorizing the release of my medical information to pay applicable claim(s). If "Other Health Information" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown. With certain insurers, the patient may be responsible for the deductible, co-payment, co-insurance, or non-covered services. Co-insurance and the deductible are based upon the charge determination of the individual carrier.

I understand that if my insurance company requires a referral form for treatment that it is my responsibility to obtain this referral prior to my appointment. If the required referral form is not received, I understand that my appointment may need to be rescheduled until such time as the referral can be obtained.

The undersigned states that they have read the materials provided or had them read to them, and they understand payment is due when services are rendered. If upon default in making payment, the undersigned agrees to pay all reasonable legal fees and costs of collection to the extent permitted by Virginia law. Each guarantor waives presentation of payment, notice of non-payment, protest, and notice of protest, and agrees to all extensions, renewals, or release, discharge or exchange of any party or collateral without notice. This note shall take effect as a sealed instrument and be enforced in accordance with the laws of the Commonwealth of Virginia. This agreement shall be binding upon and inure to the benefit of the parties, their successors, heirs, assigns and personal representatives.

I understand that if I do not show up for a scheduled visit or provide the office with a 24-hour notice, I will be charged a NO SHOW fee. The following visits have different cancellation/no show fees.

-General Dermatology = $25 -Cosmetic Services = $40 -Phototherapy Services = $25

I understand that if I do not show up for a scheduled surgery or provide the office with a 48-hour notice, I will be changed a NO SHOW fee. The following visit will have the following cancellation/no show fee.

-Surgical Appointments = $75

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before your next scheduled appointment.

I have read, understand, and agree to this financial policy. I understand that any charges that are not covered by my insurance company, as well as applicable co-payments and deductibles, are my personal responsibility.

I acknowledge that I have been given the opportunity to receive/read a copy of Associates in Dermatology, Inc.'s Notice of Privacy Practices.

I authorize Associates in Dermatology, Inc. to leave a detailed message on my answering machine and/or voicemail.
YES NO

I authorize Associates in Dermatology, Inc. to send a text and/or email. YES NO

I authorize Associates in Dermatology, Inc. to discuss my information with the following people:
(Please make changes as needed. Please date and initial)

1. Name: _____ Relationship to Patient: _____
   May Discuss: Medical Care / Billing Information / Both
2. Name: _____ Relationship to Patient: _____
   May Discuss: Medical Care / Billing Information / Both

_____ _____ _____
Signature of Patient/Guardian **Print Name** **Date**

Assignment of Benefits:

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/or all commercial payors to make payments on my behalf directly to Associates in Dermatology, Inc. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

Signed _____ **Date** _____