APD Adult & Pediatric Dermatology
Medical Cosmetic

Patient Agreement Form

Section 1 – Patient Financial Responsibility Agreement

I hereby authorize the release of pertinent medical information to my insurance carriers. I am aware that health insurance coverage varies and, while insurance carriers must use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by the physicians of Adult & Pediatric Dermatology and any other charges for laboratory fees, pathology fees, and any other fees incurred as a result of the treatment rendered to myself or my immediate family. If I have insurance which the doctors are contracted with, **I understand that I will be responsible for any co-payments, deductibles, co-insurances, or a procedure that is not considered medically necessary by my insurance company.**

Patient Account Charges and Statements: Co-Payment and/or any balance due on your account are requested at the time of your scheduled visit; we accept cash, check, and credit card. You may contact our billing personnel to arrange and sign a monthly payment plan agreement if necessary. If you have no insurance plan at the time of your visit you will be required to pay 100% of the visit charges before being seen by our practice.

Collections: In the event I fail to pay the balance of my account to Adult & Pediatric Dermatology, I hereby agree that, in the event Adult & Pediatric Dermatology sends my account to a collection agency, I will pay the fee charged by the collection agency to Adult & Pediatric Dermatology. In addition, if my account is forwarded to an attorney to undertake legal action to collect the unpaid balances, I hereby agree to pay all of the reasonable attorney's fees incurred by Adult & Pediatric Dermatology in regards to the collection of this unpaid account. I have also been given a copy of the Office Policy and understand that the Office Policy is incorporated by reference and made a part hereof this agreement.

Returned Checks: All returned checks are subject to a $12.00 bank fee. In addition to the returned check, you will also be required to pay any outstanding balance by your next scheduled visit. As a result, you may be placed on a cash/credit card only payment method for future appointments.

No Show and Cancellation Charges: As a courtesy to our physicians, staff, and other patients, we ask that you cancel your appointments at least 24 hours in advance. There is a $50.00 fee for not showing up for your appointment or cancelling your appointments with less than 24 hours notice. The no-show fee is $50 for a regular medical visit and 50% of the anticipated cost of scheduled surgical procedures. Cosmetic services require a 48-hour notice of cancellation. No-show charges are not billable to your insurance. True emergencies will be handled accordingly between the parent(s)/guarantor and the office manager.

By signing below, you are agreeing to and understand the above financial agreement and that you understand, as the parent and/or guarantor of the minor child described above as being the patient, that you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

_____ _____ _____

Print Patient/Responsible Party **Signature** Patient/Responsible Party **Date**

Section 2 - Notice of Privacy Practices & Patient-Provider Partnership - Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Adult & Pediatric Dermatology as well as the Patient-Provider Partnership brochure. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA"). We encourage you to read it in full. The Patient-Provider Partnership brochure describes how we can work together to provide you with the best possible care (please see receptionist if you wish to take a copy home).

_____ _____ _____

Print Patient/Responsible Party **Signature** Patient/Responsible Party **Date**