

RECEIPT OF PRIVACY PRACTICES

Date Received: _____ Patient Name: _____ DOB: _____

I, _____ acknowledge that I may ask for a copy of Summit Dermatology's Notice of Privacy Practices. This describes how Summit Dermatology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of patient, parent or personal representative

Date of birth

PATIENT'S BILLING AGREEMENT PLEASE READ CAREFULLY!

- I hereby request and authorize Summit Dermatology, P.C. physicians and personnel to deliver medical care to me or my minor child that I am signing for.
- Co-pays will be collected at all visits from any patient whose insurance plan requires co-pays. I understand that, under the terms of the contract that I have with my insurance company, I MUST pay any predetermined co-payments at every visit.
- If the co-pay is not collected at the time of service and therefore results in Summit Dermatology having to send a statement, there will be a \$10.00 service fee added to the amount due.
- I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information that I have provided, I will be billed and payment in full will be due immediately.
- If I have insurance that Summit Dermatology, P.C. IS contracted with I authorize assignment of payment directly to Summit Dermatology, P.C. for services provided me. I understand that Summit Dermatology, P.C. will file the claim with my insurance but that it is my responsibility to make sure the insurance company pays my claim within 60 days of the date of service. After billing your insurance company, all services not paid in full may become your financial responsibility, to include non-covered services and services deemed cosmetic by your plan.
- If I have insurance that Summit Dermatology, P.C. is NOT contracted with I agree to pay my bill in full at the time the services are rendered, unless prior arrangements have been made with the billing office of Summit Dermatology, P.C..
- I understand that if I do not have insurance, that I am required to pay my bill in full at the time the services are rendered.
- I understand that Summit Dermatology, P.C. requires at least 24 hour notice of any cancelled or missed appointments or I could be subject to a \$35.00 fee.
- I understand that it is the policy of Summit Dermatology, P.C. to reschedule any appointment that I am more than 10 minutes late for.
- I understand that if my account or any account that I am responsible for is sent to a collection agency for non payment, I may be assessed an additional fee (interest, attorney/legal fees and court costs) and will face possible dismissal from care at Summit Dermatology, P.C.
- I understand that my minor child MUST be seen at their first visit with a parent or legal guardian present, no exceptions.
- I understand that my minor child MUST have a parent or legal guardian present at ALL visits unless the parent or legal guardian has signed a consent form for minor patients PRIOR to the follow up appointment.
- I understand that regardless of who is listed as the RESPONSIBLE PARTY for any financial obligations owed to Summit Dermatology, P.C. the person that signs below is ultimately the person responsible for payment on this account.
- I understand that any biopsies or excisions done in this office are sent to a pathologist for testing and associated charges are separate from the charges incurred in this office, and are my responsibility. I understand that Summit Dermatology, P.C. will forward the insurance information they have on file for me. Summit Dermatology, P.C. will use the pathologist specified by my insurance to the best of their ability, however there are cases in which the provider at Summit Dermatology, P.C. may find it necessary to go out of network to receive the best medical testing and diagnosis possible in my situation.

Your signature below signifies your understanding of the Billing Agreement of Summit Dermatology, P.C. and your willingness to comply. It also states that you have reviewed and verified that your demographic information is correct to include your current address, phone numbers and insurance information. This signature consents to treatment at Summit Dermatology, P.C. and acceptance of the financial responsibility with that treatment.

Signature of Patient or Responsible Party _____ Date _____

Name of person signing _____ Relationship _____