OFFICE POLICY

To ensure quality service, we have set forth the following office policy. Please review this form and sign at the designated areas.

1. We require certain information at each visit. This includes a current insurance card and any changes in your demographic information (change of address, phone number, policy holders, etc.).
2. Some insurance plans require a referral from your primary care physician. You are responsible for obtaining the referral, knowing the number of visits on the referral and knowing the expiration date of the referral.
3. We will verify your insurance benefits at each visit but it is ultimately **your responsibility to know what your insurance coverage entails**. This includes knowing the deductible amount and the amount you have met, the co-pay amount, and the coverage policies for procedures. Most procedures performed in the office are considered surgical by the insurance companies and may be subject to a deductible and/or co-insurance in addition to your co-pay. Some examples include destruction of warts and other lesions with liquid nitrogen or other chemicals.
4. Certain tests may be necessary in order to provide optimum care. Some of these tests include blood work, x-rays and/or biopsies. If your insurance plan does not cover the tests then you will receive a separate bill from the specific lab facility.
5. **All deductible charges and co-pays** must be paid at the time service is rendered.
6. If you are late for your office visit, we reserve the right to reschedule your appointment to another time or day.
7. Please give us at least 24 hours notice of an appointment cancellation so that other patients with more acute conditions may be seen sooner. We reserve the right to charge for appointments canceled without 24 hours advance notice. We charge **$25 for regular office visits** and **$40 for surgery/procedure visits**.
8. We accept checks, cash and major credit cards. There is a $30 charge for all returned checks.

I acknowledge full financial responsibility for professional services rendered to myself and/or my dependants. I understand that I am responsible for any charges that are not covered by my insurance plan. I authorize the release of medical and other information necessary to process insurance claims on my behalf. In addition, I authorize payment of medical benefits to Alliance Dermatology, PC for services provided. By signing below, I agree to all parts of this office policy.

Patient Name (Print): _____ Date: _____

Patient/ guardian Signature: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that healthcare information is recorded and maintained in order to provide quality medical care. Alliance Dermatology, PC is committed to protecting this information. The Notice of Privacy Practices describes your rights with regards to health information, as well as how this information is used in order to carry out treatment, payment and healthcare operation (TPO). It also describes how we must protect the confidentiality of this information. I have the right to review the Notice of Privacy Practices prior to signing this form. I understand that Alliance Dermatology, PC reserves the right to revise its Notice of Privacy Practices at anytime and I may obtain this revision with a written request. I may request restrictions as to how my health information may be used or disclosed to carry out TPO. However, this practice is not required to agree to the requested restrictions. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of TPO. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

Patient Name: _____ Patient/guardian Signature: _____ Date: _____

I authorize the release of my health information to the following person(s)/entity:

Name: _____ Relationship: _____