Acknowledgement of Receipt of Notice of Privacy Practices & Patient Financial Policy

Full Name: ___________________________________ Date of Birth: __________ /___________/_________________

Printed Name

I received a Notice of Privacy Practices. ____

(see blue paper handout) **Patient Signature**

I give permission for photographs to be taken (profile, lesions, biopsy sites, rashes) for documentation purposes in my medical record. I will remind the medical assistant if I don't want photos. _______________________________________

Patient Signature

For your convenience we accept cash, check, MasterCard and Visa. *(There is a $30.00 charge for a returned check)*

<u>General responsibility for payment</u>: **Your co-pay, co-insurance, or deductible is expected at the time of service**. We will file a claim with your insurance company if we participate. Please make sure your billing information is complete and accurate. *For commercial insurance it is imperative that the primary insured (employee and first on the insurance card) information is complete for a claim to be processed*. You are responsible for payment of any office visits and procedures for which your insurance company denies payment. We will try to advise you when we think a procedure might be denied. However, sometimes we are not aware of a denial until after the claim has been filed.

<u>Regarding non-covered services:</u> Services which your insurance company considers cosmetic or not medically necessary you will not be reimbursed by your insurance company. **Payment in full is due at the time of service**. *(ex: removal of skin tags, milia cysts, normal moles, benign asymptomatic keratoses, oil glands, blood vessels and some warts; skin discoloration and male pattern hair loss.)*

<u>Regarding HMO's that require a referral</u>: Obtaining a referral with the correct diagnosis is the patient's responsibility. If a referral is not in the office for the problem that you want addressed, the full cost of the visit is due at the time of service.

<u>Regarding insurance that we do not have a contract with</u>: The total cost of the visit is due at the time of service.

<u>Third party claims</u>: We do not bill other parties such as financially responsible parents or employers. When a **minor** is present for care, the person presenting the minor is responsible for payment at the time of service.

If at any time you have questions about the cost of a service, you may ask to speak to someone in our business office.

MISSED APPOINTMENTS OR CANCELLATIONS THE DAY OF YOUR APPOINTMENT: Please call 2 business days in advance to cancel an appointment. You will be charged a **$50** fee for missed appointments not cancelled within 2 business days. You will need to schedule future appointments on the morning you wish to be seen, depending on availability.

I authorize my insurance company to pay benefits on my behalf to Lisa Abernethy Christman, M.D., Dermatology, P.A.

I understand and accept this financial policy.

____ Date: ____/____/20____

Patient Signature

For Medicare patients with Medigap: I authorize Medigap benefits made on my behalf.

____ Date: ____/____/20____

Patient Signature