FINANCIAL AGREEMENT – ACKNOWLEDGEMENT & CONSENT FORM

At PBC Dermatology we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

A CURRENT GOVERNMENT ISSUED PHOTO ID AND CURRENT INSURANCE CARD (IF YOU ARE REQUESTING US TO BILL YOUR INSURANCE COMPANY) MUST BE PRESENTED AT INITIAL VISIT. FAILURE TO PROVIDE US WITH EITHER OF THESE MAY REQUIRE US TO RESCHEDULE YOUR APPOINTMENT.

PATIENTS MUST FILL OUT ALL PATIENT INFORMATION FORMS PRIOR TO SEEING THE PHYSICIAN.

APPOINTMENTS

24 hour notice must be provided in the event that you cannot keep an appointment. Should you not provide this notice, a fee of $50.00 will be added to your account.

LATE NOTICE

All patients must arrive on time to their appointment. This ensures your physician stays on schedule and is able to give each patient the time and attention they deserve. **If you arrive after your scheduled appointment time you may be rescheduled.**

EXPECTED AMOUNT DUE

By law we MUST collect your insurance carriers' designated co-pay/co-insurance and/or deductible at each visit. This payment is expected at the time of service. Please be prepared to pay the expected amount due at each visit. The patient will be responsible for any portion of his or her bill that is not covered by the insurance carrier. If you are a SELF-PAY PATIENT, the payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Some procedures and surgeries are considered "cosmetic" or "not medically necessary" and may not be covered by your insurance; all cosmetic procedures are due and payable at the time of visit

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of PBC Dermatology. I realize that if a medical procedure or surgery is required, I will be given additional information.

IN THE EVENT THAT A BIOPSY IS PERFORMED

I understand and consent to the following:

I may be responsible for a separate fee related to processing and examination of my tissue specimen(s). Tissue specimen(s) will be sent to a laboratory designated by my insurance company for analysis to confirm a diagnosis. Furthermore, additional costs may be incurred for consultation fees and from additional special studies if indicated.

Any additional questions or issues must be addressed with my insurance carrier. I am responsible for all costs which are not covered by my insurance plan. If I do not have insurance coverage, I assume all financial responsibility with laboratory fees.

My signature below indicates that I have read and am in agreement with all of above:

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ RELATIONSHIP TO PATIENT: _____