KLEYDMAN DERMATOLOGY

PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____
Last Name First Name

By signing this document below and by initialing each paragraph, the patient or responsible party listed above acknowledges they have read and understood the following:

FINANCIAL RESPONSIBILITY

Payment for office services or the co-payments and/or the co-insurance is payable when service is rendered. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Cosmetic & Laser procedures are not covered by insurance and the fees are the responsibility of the patient. Payment for medical services is between Kleydman Dermatology, PLLC and the patient/responsible party. Therefore, Kleydman Dermatology, PLLC cannot accept responsibility for collecting or negotiation settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness, liability claim, (4) claim where patient is or will be represented by an attorney, and/or (5) claim to be settled in a court of law.

INSURANCE LIMITATIONS

Most insurance carriers require a written referral from a Primary Care Physician in advance of service provided by Kleydman Dermatology, PLLC. Patients or person responsible for the patient must (1) obtain physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles and co-insurances. Patients are also responsible for any penalties imposed by their insurance company for seeing the patient out-of-network. Kleydman Dermatology, PLLC will file a patient's insurance as a courtesy. I understand that I am responsible for notifying Kleydman Dermatology, PLLC office of any changes to my healthcare plan. At the time of the visit I am responsible to provide a valid insurance card. I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP (primary care physician) change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment for services rendered.

ASSIGNMENT OF MEDICAL BENENFITS

The patient or responsible party certifies that information provided relative to injury, illness, and insurance coverage is both true and correct. By signing this form the patient or responsible party authorizes payment of insurance benefits or proceeds from any liability claim or legal or court settlement to be assigned to Kleydman Dermatology, PLLC to the extent that their charges are paid in full.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician to release any record and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

PHYSICIAN ASSISTANTS & MEDICAL ASSISTANTS

Kleydman Dermatology, PLLC utilizes Physician Assistants & Medical Assistants in our offices. Physician Assistants & Medical Assistants may provide care for you during your visit. By signing this form you give permission to have Physician Assistants assist in your care.

CONSENT TO TREAT

I hereby voluntary consent to my treatment at Kleydman Dermatology, PLLC and authorize such treatments, examinations and diagnostic procedures as ordered by my attending/ covering physician.

CONSENT TO PHOTOGRAPH

I agree that Kleydman Dermatology, PLLC may take a digital photo of me. I understand that: The photo will be stored permanently in my medical record. The photo will be used to identify me when I come here for care. The photo will be stored securely to protect my privacy. The photo will NOT be used outside of Kleydman Dermatology, PLLC, unless I (or my legal representative) give my permission in writing. Kleydman Dermatology, PLLC will own the photo. I can look at the photo, or get copies, if I (or my legal representatives) sign a release form.

IDENTIFICATION

I am required to provide a valid identification card for every visit to Kleydman Dermatology, PLLC.

REFERRAL INFORMATION

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I understand that should I fail to present a valid referral for my visit I would be responsible for charges pertaining to seeing a specialist.

CANCELLATION POLICY

Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact the office with at least 24 hours notice will result in a **$25 fee for regular visit and $50 fee for cosmetic and/or surgical.** This fee is not reimbursable by your insurance company.

PATIENT HIPAA CONSENT

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name: _____Signature: _____ Date:_____

Responsible Party Name: _____Signature:_____Date:_____

(If different from Patient)