Dermatology Practice of the Carolinas, PA

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CHART # _____ **Patient Acknowledgement of Receipt -Consent Form**

Patient's Name_____ Date of Birth ____/____/_____

I consent to necessary treatment, including drug, medicines, performance of operations and conduct of studies that may be conducted by DPC.

I understand that I may be charged **$45 for a missed medical appointment, $75 for a cosmetic appointment** or cancellation if I do not notify DPC 24 hours in advance of appointment.

I understand that **if I am uninsured or have an insurance that is not accepted** at the practice, that I will be responsible for payment IN FULL at the time of service.

I understand that **insurance copays, deductibles, co-insurance and charges not filed with insurance are due at the time of service**. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State of North Carolina and any other state.

I understand that **I will be responsible for ANY charges that are not paid by my insurance company**. Not all services are covered, and I understand that it is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies. (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file your own claims.)

I understand that **if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to my appointment**.

I understand that **most procedures may fall under major medical, therefore I will be responsible for paying the deductible amount at the time of service**. Procedures include treatment of skin lesions (including warts, molluscum, moles, tags, precancers, skin cancers) by ANY method (including freezing, biopsy and in-office application of medication).

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

If I am a **Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or any related Medicare claim/other insurance company claim**. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply .I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

I am aware that the practice has a **Notice of Privacy Practices** that contains a section on Patient Rights. I have been given the opportunity to review this Notice.

Patient or Responsible Party (signature) _____Date ____/____/____