

**REFERRAL INFORMATION
PATIENT FINANCIAL POLICY AND
SIGNATURE ON FILE**

Patient Name: _____ Today's Date ____ / ____ / ____

Other family members that are patients _____

Referred by: _____ Primary Care Physician _____

Pharmacy of choice _____ Phone () _____

In case of Emergency, who should be notified? _____ Phone () _____

RELEASE OF INFORMATION:

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.

Patient or Responsible Party Signature _____ Date ____ / ____ / ____

PAYMENT POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a \$25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____ / ____ / ____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare 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.

Signature as it appears on Medicare Card _____ Date ____ / ____ / ____

If you have a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized Supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Supplemental Card _____ Date ____ / ____ / ____

Thank you for choosing this office to assist in caring for your skin.