

Fayette Area Dermatology

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I had an opportunity to review the Notice of Privacy Practices for the above named practice, and understand that I may have a copy to take with me if I choose.

Patient Signature or Responsible Party

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reasons:

Prepared By: _____

Signature _____

Date: _____

You have the right to refuse treatment at any time; however, once treatment is rendered, payment is required. Payment is expected at the time of service.

Private Pay- I understand & agree that payment is due & payable at the time of service.

Health Insurance- I understand that each time I am seen in the office for an evaluation and/or treatment an office visit can be charged in addition to any other charges. I understand that outside laboratories may be used for skin biopsies and/or cultures and that I may receive a separate bill for these services. I understand & agree that I will need to provide a current copy of my insurance card to the office staff at the time of each visit. I fully understand that I am financially responsible for all monies not covered by my insurance provider including but not limited to deductibles, co-payments, coinsurance or any unpaid portion of the claim.

Medicare: I understand that I am responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of service. Our billing service will file the claim for you and then you will be billed according to the amount due.

I understand that checks are not accepted for cosmetic procedures or products. We do accept checks, credit cards or cash for medical services rendered and/or copays. I do understand there will be a \$25.00 fee charged for any return checks.

Cancellation Policy: You agree to a charge of \$25.00 for any appointment cancelled less than 24 hours in advance, or if you fail to show up for your appointment. If you fail to cancel or keep a cosmetic appointment, you will forfeit your deposit.