

Patient Signature Form**Financial Policy for all patients, including Medicare**

Dermatology Specialists of Charlotte (DSC) is considered a specialist office. Some insurance policies require that prior to your office visit; you must obtain a referral from your primary care physician. If this is not acquired prior to your visit, you may be asked to reschedule your appointment or pay for your visit in full. Payment is required for all services at the time they are rendered unless you are covered under an insurance policy in which we participate. For those patients, applicable co-payments, deductibles, and/or coinsurance will be collected at the time of service. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial policy statement. I agree to make prompt payment in full to DSC when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered (i.e. cosmetic services). Further, I authorize payment directly to DSC for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

Signature: _____ Date: ____/____/____

Financial Policy – Medicare Patients Only

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 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: _____ Date: ____/____/____

Privacy Practices (HIPAA)*Receipt of Privacy Practices*

By signing below, I acknowledge that I have the right to review a copy of the Notice of Privacy Practices prior to signing this consent. 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.

Signature: _____ Date: ____/____/____

Contact Information

By signing below, I authorize DSC to leave a message in reference to any items that assist the practice in carrying out healthcare operations.

Please list any persons to whom your protected health information can be disclosed.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: ____/____/____

Permission To Treat A Minor (Age < 18 years of age)

A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visit in which a procedure is performed. The parent/ guardian grants permission to DSC to see the minor without their presence for standard medical office visits. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Signature: _____

Relationship to Patient: _____ Date: ____/____/____