Advanced Dermatology, PC
Skin Cancer Surgery & Skin Care Center

Notice of Privacy Practices and Patient Financial & Cancelation Policies

Last Name _____ First Name _____
Date of Birth _____/____/_____ Date ____/____/_____

Thank you for choosing Advanced Dermatology for your healthcare needs. Please read the following policies and complete the sections below. Please contact a practice administrator if you have any questions.

NOTICE OF PRIVACY PRACTICES: We are required by law to provide you with a copy of our Notices of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our client services staff to acknowledge that you have been provided a copy of our notice.

FINANCIAL POLICY: Advanced Dermatology has contracts with many insurance plans. Due to the numerous healthcare plans available, it is the patient's responsibility to verify that we are in network with your specific insurance plan.

If we contract with your plan, we will file a claim (for non-cosmetic dermatology services) to your insurance company. You will be responsible for any co-pays, deductibles, purchased products, and/or non-covered service. If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of your service.

- Should any blood work or pathology be done, a separate invoice will be sent to you from our contracted lab, which will be your responsibility to pay directly to them.
- If your plan requires any referral authorizations from your primary care physician, it is your responsibility to obtain this.
- It is your responsibility to provide Advanced Dermatology with your current insurance information. Failure to do so may result in charges being billed directly to you.
- Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility. Any outstanding balances over 90 days will be charged to your credit card. If applicable a 3% late fee will be accessed to balances over 90 days and/or patient will be sent to our collection agency.
- All cosmetic and laser services must be paid at the time of service or will be charged to the credit card on file.
- Any returned check will result in a $30.00 penalty fee.

CANCELATION POLICY:

- **MEDICAL PATIENTS**: Please be advised that we require at least 24 hr notice to cancel or reschedule a medical appointment. A $25 fee will be assessed to your account with a cancelation or reschedule of less than 24 hours notice and will be charged to the credit card on file, $50.00 for No Show fees
- **COSMETIC PATIENTS**: Please be advised that we require at least 72 hr notice to cancel or reschedule a cosmetic appointment. Should you cancel or reschedule less than 72 hours; a non-refundable fee of $50 per 30 minutes of appointment time will be assessed to your account and will be charged to the credit card on file, $100.00 for No Show Fees
- **LATE ARRIVAL**: All patients who are more than 15 minutes late for their appointment may not be seen and may be rescheduled.

For your convenience, we accept cash, checks, Visa, MasterCard, American Express, and Discover as payment options. If you have any questions about coverage and/or payment, feel free to ask in advance of services being rendered.

Please provide your credit card number in the line below:

_____ _____ _____
Credit Card Number **Exp Date** **3/4 Digit Code**

I certify that I have been provided with the Notice of Privacy Practices and the Patient Financial & Cancelation Policies. I have read and accept the policies of Advanced Dermatology.
I authorize Advanced Dermatology, PA, to charge my credit card any outstanding balances over 90 days as well as the appropriate cancelation fee if needed.
I authorize payment of medical benefits to the named provider for professional services rendered.
I authorize the release of any medical information necessary to process any claims filed.

Date ___/___/_____ _____
Signature of Patient (or Legal Representative)

Date ___/___/_____ _____ _____
Signature of Staff Member Title

Refills: Prescription refill request often require an office visit before we can fill the refill request, this is to ensure your safety. Should you desire a prescription refill, please have your pharmacist fax the request to us at (856) 256-8868.

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