Patient Name: _____ **Date of Birth:** _____/_____/_____

Statement of Patient Financial Responsibility

Aesthetic Dermatology appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know your coverage and benefits**.

You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. **It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Aesthetic Dermatology**.

I authorize Aesthetic Dermatology to furnish information to insurance carriers concerning my care.

Initial _____

If any tests are performed by the lab you may receive a separate bill from their offices that you are financially responsible for. We use an experienced and trusted derma pathologist to review our biopsies. If you prefer to have your specimen reviewed by a general pathologist at a lab of your choice, you must let us know prior to your visit.

If payment is denied for lack of authorization, I understand that I am responsible for payment in full.

Initial_____

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Some health insurance carriers require the patient to pay a copay for services rendered. This is a contract between you and your insurance carrier. Payment of all co-pays is expected at the time the service is rendered for the patients.

I understand that I am responsible for co-payments and deductible/co-insurance as dictated by my insurance carrier.

Initial_____

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due.

Initial_____

All cosmetic procedures (those not covered by medical insurance) must be paid in full at time of service and are non- refundable

Initial _____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, you must call the office 48 hours prior to your appointment time to cancel or reschedule your appointment. I understand if I miss an appointment without canceling in advance I will be charged a $50 no show fee and a $25 cancelation fee if not done within 48 hours and I will not be allowed to schedule another appointment until that fee is paid in full.

Initial_____

Record Release Acknowledgement

I, _____ understand that I can access my medical records through the internet via my patient portal at no charge. Fees for sending medical records include a $10.00 records processing fee and $0.50 per page.

I have read the above policy regarding my financial responsibility to Aesthetic Dermatology, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Aesthetic Dermatology. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

_____

(Signature of patient OR parent/guardian if under the age of 18)

(Date)

_____

(Print Name)