

## Affiliated Dermatologists of Virginia

### Notice of Financial Policy, Privacy Act and Consent Treatment

- **Consent for treatment**

I authorize Affiliated Dermatologists of Virginia to render service and treatment to me/my dependent for dermatological care.

- **Assignment of Benefits/Release of medical information**

I hereby assign all right, title, and interest and direct that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Affiliated Dermatologists of Virginia for services provided under their care. I also authorize Affiliated Dermatologists of Virginia to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

- **Financial Responsibility**

I understand that I am ultimately responsible for all charges including any unpaid balance or services not covered by my insurance or another third party payment provider. I understand that Affiliated Dermatologists of Virginia will bill my insurance company or Medicare as a convenience to me, however, I remain obligated to communicate with the insurance company and seek timely processing and payment of my claim. I, \_\_\_\_\_ am obligated to inform this office of insurance coverage changes prior to my appointment to ensure correct billing. **If my account is more than thirty days past due it will be considered delinquent and will be turned over for collection.** At that time my relationship with this office will be terminated within 30 days, thereafter. Medical care will only be provided during that 30 day period for emergency care only. I will also be responsible for all costs of all collection, including but not limited to all collection fees and attorney's fees of not less than twenty-five percent of any unpaid balances plus court cost.

- **Referrals/Authorizations**

I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of such service.

- **Missed Appointments**

Affiliated Dermatologists of Virginia requires at least 24 hour notice for cancellations. Failure to do so may result in a \$50.00 fee.

#### **Notice of Privacy Practices**

- My signature below also indicates that I have received and/or reviewed a copy of this Notice and agree to and acknowledge the terms and my responsibilities. I understand that I may ask questions of Affiliated Dermatologists of Virginia if I do not understand any information contained in this Notice. With my consent Affiliated Dermatologists may:

*-Call My home or other designated location provided by me or on my behalf and leave a detailed message on voice mail in reference to appointment reminders, insurance or billing items.*

*-Call my home or other designated location and leave a detailed message on voice mail in reference to my clinical care, including laboratory results. Preferred number for Clinical messages \_\_\_\_\_.*

*Affiliated Dermatologists of Virginia or its agents may also mail to my home or other designated location any items that assist the practice in carrying out its business, such as appointment reminder cards and patient statements.*

I hereby agree to the foregoing terms and conditions of this Notice.

\_\_\_\_\_  
Patient Signature  
(Or Parent/Legal guardian of minor)

\_\_\_\_\_  
Date