



advanced  
DERMATOLOGY

**Notice of Privacy Practices and Patient Financial & Cancellation 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 as indicated 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 **Notice of Privacy Practices** (please see document as titled in our practice intake forms). To ensure that our records are accurate, please sign this form and return it to our administrative staff to acknowledge that you have been provided a copy of our Notice.

**FINANCIAL POLICY:** Advanced Dermatology has contracts with many insurance plans. Please check with our reception staff to determine whether we participate with your specific insurance carrier.

We will file a claim (for non-cosmetic dermatology services) to your insurance company if we contract with your plan. 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 service.

- Should any blood work be done, a separate invoice will be sent to you from our contracted lab, which will be your responsibility to pay directly to them. This is in addition to our charges.
- Many plans, including HMO and POS plans, require referral authorization from your Primary Care Provider (PCP) in order for your visit with us to be covered. It is your responsibility to obtain this information.
- All laser and cosmetic appointments rendered in our office require full payment at the time of service. We do not bill for these services, even if your plan is one with which we contract, as they are deemed "elective" and not medically necessary.

**CANCELLATION POLICY: All appointments must be held with a valid credit card in order to make an appointment.**

- **MEDICAL PATIENTS:** Please be advised that we require at least a 24 hr notice to cancel an appointment. A \$50 fee will be assessed to your account with a cancellation of less than 24 hrs notice and will be charged to the credit card on file. 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. Patient will be responsible for any collection fees owed from delinquent accounts.
- **COSMETIC PATIENTS:** Please be advised we require at least a 72 hr notice to cancel a cosmetic appointment. Should you cancel less than 3 business days a non-refundable fee of \$100 per 30 minutes of appointment time will be assessed to your account. All cosmetic and laser services must be paid at the time of service or will be charged to the credit card on file.
- **LATE ARRIVAL:** All patients that are more than 15 minutes late for their appointment will not be seen, may be rescheduled and will be treated as a "late cancellation." Please arrive for your appointment on time and 5-10 minutes early if necessary to fill out any required office paperwork.

*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:		
_____	_____	_____
<b>Credit Card Number</b>	<b>Exp Date</b>	<b>3 Digit Code</b>

**I certify that I have been provided with the Notice of Privacy Practices and the Patient Financial & Cancellation Policies. I have read and accept the policies of Advanced Dermatology, LLC.**

**I authorize Advanced Dermatology, LLC to charge my credit card the appropriate cancellation 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