DR. ERIC FINZI & ASSOCIATES

*General & Cosmetic Dermatology*

Chevy Chase Cosmetic Center • 240-482-2555 | Dermatology & Cosmetic Surgery Associates • 301-345-7375

## Payment Consent And Assignment - PLEASE READ CAREFULLY BEFORE SIGNING

**INSURANCE ASSIGNMENT:** If you have insurance, a claim for reimbursement for services rendered today will be submitted based on the information you provided to *Dermatology & Cosmetic Surgery, Associates* and/or *Chevy Chase Cosmetic Center*. You agree to authorize and assign insurance/workers compensation payments for such services to our practice, and authorize the release of your private health information for treatment, reimbursement and billing purposes. You understand that it is your responsibility to pay for non-covered services, co-insurances, co-payments and deductibles. Our practice will rely on the information you provide on the day of your visit to submit a claim for reimbursement and additional laboratory tests if necessary.

**MEDICARE PATIENTS:** This consent authorizes the release of your health information to the Social Security Administration and the Centers for Medicaid and Medicare Services or, its intermediaries, or any information needed for this and related Medicare claims. You agree to request payment of medical insurance benefits to our practice. You understand that you are responsible for any health insurance deductibles, co-payments and non-covered services/ procedures, including but not limited to all charges for laboratory testing associated with your visit.

**MEDIGAP PATIENTS:** This consent authorizes MEDIGAP (secondary) benefits be made on your behalf for any services furnished to you. You authorize our office to release any of your medical information needed to determine these benefits or the benefits payable for related services.

**REFERRALS:** You understand it is your responsibility to obtain a referral from your primary care physician prior to your appointment, if required by your insurance carrier. If a valid referral is not present at the time of your appointment, you will have to reschedule or pay in full prior to being seen.

**LABORTATORY FEES:** Services such as biopsies, excisions, shaves and other skin removal surgeries, require lab testing to confirm a diagnosis and rule out skin cancer. You agree to the practice conducting such testing at *Dermatology & Cosmetic Surgery, Associates*, and/or at an outside laboratory deemed appropriate for microscopic slide processing and interpretation. For insured patients, we will provide the laboratory with your insurance information and you will receive separate bills for any lab services rendered. You understand we do not control the costs of lab fees from an outside pathologist/laboratory.

**SELF-PAY PATIENTS:** Payment is due in full for all services rendered on the day of service. If laboratory testing is required, you will be billed directly from the laboratory after the lab services are completed.

**BALANCES:** Outstanding patient balances greater than 90 days will be assigned to a collection agency. All past due balances must be paid before rendering additional services. Returned checks are subject to a $30 additional fee. All billing questions must be directed to our billing department at 1-888-222-2125.

**MISSED APPOINTMENTS:** Your appointment time is reserved specifically for you. We ask that you give 24 hour notice if you need to cancel your appointment. **A fee of $50.00 will be charged for missed appointments and/or appointments not cancelled 24 hours in advance.** We understand that emergency circumstances may arise and could result in a missed appointment or canceling the same day. If an emergency occurs, please contact our office to inquire about waiving this fee. Subsequent missed or same day canceling of an appointment will result in the fee(s) being collected prior to any future appointment request.

This agreement is valid for all episodes of care rendered by the providers associated with *Dermatology & Cosmetic Surgery Associates* and *Chevy Chase Cosmetic Center*. **Your signature below acknowledges that you agree to the policies outlined and consent to treatment, diagnostic and/or cosmetic services as ordered and/or provided by the physician(s) and providers *of Dermatology & Cosmetic Surgery, Associates* and/or *Chevy Chase Cosmetic Center*.**

**X**_____

**Patient/Legal Guardian Signature** **Date**

## NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

We are required to provide you with a copy of our **Notice of Privacy Practices (ATTACHED)** which states how we may use and/or disclose your health information. Please read and sign this form to acknowledge receipt of the notice.

**I am a patient OR parent/legal guardian of a patient of Dermatology & Cosmetic Surgery, Associates/Chevy Chase Cosmetic Center and I hereby acknowledge receipt of their Notice of Privacy Practices with my signature.**

**X**_____

**Patient Full Name**

**X**_____ _____

**Patient/Legal Guardian Signature** **Date**

REVISED 1/20/2016