Park Avenue Dermatology
PATIENT ACKNOWEDGEMENT OF OFFICE POLICIES

APPOINTMENT CANCELLATIONS: INITIAL_____

If I am unable to keep my scheduled appointment, I will call the office to cancel or re-schedule my medical appointment at least 24 hours in advance. Surgical appointments require 48 hours cancellation notice. If I do NOT call the office, I understand I will be required to pay a $50 no-show fee. You can call or e-mail us at parkavederm@hotmail.com

CO-PAYMENTS: INITIAL_____

Co-payments are due and collected on the day of my or my family's appointment. It is my responsibility to know my co-payment amount. Returned Checks (NSF) or Stopped payment on credit card --ALL FEES WOULD BE PAID BY THE PATIENTS $35 to $50 depending on the bank.

INSURANCE REFERRALS: INITIAL_____

If my insurance plan requires a referral, I understand it is my responsibility to check and to obtain an updated referral from my Primary Care Provider and to make sure that the office has the referral before my visit. I understand it is my responsibility to keep track of the number of visits I have used on the referral and the expiration date and obtain new ones as needed. I understand should I fail to have a valid referral for my visit, the doctor is not authorized to see me. It will be my decision to either re-schedule my visit or be seen that day and be considered a self-paid patient and will be responsible for all charges incurred. I understand my insurance company will not cover any visit where a valid referral is not in place.

INSURANCE CARDS: INITIAL_____

We require you to confirm that your insurance is current at each office visit and that doctor is in network (if you don't want to pay higher out of network deductibles). New patients or existing patients with a change in their insurance information must provide a valid insurance card at the time of the visit. Should you be unable to produce this documentation, you are required to pay in full at the time of the service and submit the claim to your insurance company yourself.

ACCOUNT BALANCES: INITIAL_____

I am responsible for the timely payment of my account balances, co-insurance and deductibles. All balances are due within 30 days of my first billing. Any balance left unpaid after 90 days without attempt at resolution will be turned to collections, which will report outstanding balance to Credit agencies that will affect my credit. If I am having financial difficulty, I understand I may contact the billing office to discuss a reasonable payment plan. If my account is sent to collections, I understand there will be an additional 15% of the total charges added to the principle balance for administrative fees as well as attorney and court charges. There is no guarantee of payment by insurance company until claim is submitted and processed. If the claim is denied for any reason or if I have a deductible or balanced bill I will be fully responsible for the balance due at the contracted rate according to agreement with my insurance company. I understand, balanced bills, co-pays and deductibles are defined by the contractual agreement with insurance company would not be considered a "surprise bill" and is required to be paid by patient.

COLLEGE STUDENTS: INITIAL_____

If you are a college student on your parents' insurance plan, your insurance company will require a form to be completed confirming your student status. These forms are mailed to your home by the insurance company and must be completed and returned within 30 days. If these forms are not returned within the time frame, your claims will be denied and the policy holder will be responsible for all charges incurred.

HIPAA PRIVACY POLICY:

Patients are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family member or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.

Name of Individual (please print) Relationship to Patient

1 _____

2 _____

I acknowledge that I understand all the above policies including Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient or Guardian Signature: X_____ Date:_____