TOTAL®
DERMATOLOGY

Consent for Treatment/Financial Agreement

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate. I also acknowledge full responsibility for the payment of all series, and agree to pay all amounts due in full at the time of service. I understand that the patient or responsible party is solely responsible for payment of all series, though the insurance may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including reasonable collection agency fees currently 24% and attorney's fees. I understand that I will be charged for any returned check.

I understand that if my insurance is Medicare, Blue Cross Blue Shield (PMD), Blue Cross HMO or any plan such as Health Springs, Viva, United Health Care, Aetna, Cigna, Secure Horizons, that some services are not always covered. T**hese plans cover services based on medical necessity. Injections, intralesional injections, hair loss treatment, keloid removal/treatment, wart removal/treatment, skin tags, clavus (corns) removal/treatment and other skin lesions are not always considered medically necessary on these insurance plans.** I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those series.

I also acknowledge as a member of these plans, that this office will submit my insurance and I will be responsible for paying all copays and/or deductibles at the time of visit as well as any cosmetic treatment.
I understand that if my insurance is an HMO that I must obtain a referral from my Primary Care Physician every visit before coming to this office for any appointment. **I understand that it is my responsibility as the patient to confirm that my referral is current and in effect before I arrive for my appointment. If no referral is obtained, I will pay for the visit.**

I authorize my insurance company to remit payment of medical benefits direct to this office for services provided by our physicians.

I understand that I may incur a $35 no-show fee if I fail to attend my visit or fail to provide this office with a notice of appointment cancellation within 24 hours of visit. The following reminders are sent beginning 5 business days prior to each appointment:

Text notification – 5 business days prior to appointment
Email notification – 3 business days prior to appointment
Phone or Text notification – 1 business day prior to appointment

I understand that Total Dermatology records each inbound and outbound telephone call for quality assurance purposes. Such phone calls will be monitored to ensure compliance with our no-show policy.

I hereby authorize the release of all medical records on the patient listed above the referring and family physicians, as well as all records necessary for the processing of insurance claims. I also authorize the release of medical records to a 3rd party PA processor, specialty pharmacy, or specialty drug program, if applicable.

This consent will remain in effect until request for termination is received in writing or until a minor patient turns 19 years of age

Patient Signature: _____ Date: _____

_____
Signature of Parent or Guardian (Child under 19 years old)