NASHVILLE SKIN COMPREHENSIVE DERMATOLOGY CENTER

AGREEMENT TO PAY

In order to establish an optimal relationship and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required at the time services are rendered unless you are covered by an insurance company with which Nashville Skin & Cancer participates. We accept payment in the form of cash, check, or credit card.

I understand that it is my responsibility to present accurate, current insurance coverage information at time of check in. At that time, I will be asked to pay for all services not covered, deductible amounts, co-pays, past due balances, as well as balances due resulting from invalid insurance information. For patients with HMO coverage or other third party insurance that require authorizations, I will be held responsible for payment if this referral authorization is not provided at the time of service. I, as the patient or responsible party for the patient, agree to be responsible for charges or services referred to another physician or laboratory by any physician/practitioner of Nashville Skin & Cancer.

I understand that failure to make payment when due is the basis for legal action, and agree to pay any and all cost of collection, including attorneys' fees.

I understand it is the policy of Nashville Skin and Cancer to collect any outstanding balance before additional services are rendered.

I authorize and request that payment by an authorized insurance company be made payable to Nashville Skin & Cancer on my behalf for the services furnished to me by the physician(s)/practitioner(s) of Nashville Skin & Cancer.

This signature verifies the agreement to the above as the patient or the responsible party for the patient.

Signature:_____ **Date:**_____

NO SHOW POLICY (EFFECTIVE 9/1/2009 & 4/1/2012)

I understand that I will be allowed one missed (no show) appointment without a penalty. After a second no show and every no show thereafter, I will be charged a $30.00 fee. 24 hours cancellation notice is required if you are unable to keep your appointment. I understand that I will be charged a $100 fee for any missed (no show) surgery/excision appointment. 24 hours cancellation notice is required if you are unable to keep your appointment.

Signature:_____ **Date:**_____

MEDICARE POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Nashville Skin & Cancer for any services or items furnished to me by the physician(s)/practitioner(s) of Nashville Skin & Cancer. I further request authorized Medigap benefits be made on my behalf to Nashville Skin & Cancer. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid services and its agents and/or my Medigap carrier, any information needed to determine these benefits or benefits payable for related services.

Signature:_____ **Date:**_____

Revised 3/27/12

Please see reverse side ⇨

NASHVILLE SKIN COMPREHENSIVE DERMATOLOGY CENTER

AUTHORIZATION TO REVEAL MEDICAL AND BILLING INFORMATION

I authorize Nashville Skin & Cancer and staff to reveal to the following individuals, as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals, Nashville Skin & Cancer will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Nashville Skin & Cancer.

1. Name:_____ Relationship:_____
2. Name:_____ Relationship:_____
3. Name:_____ Relationship:_____

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have read and understand the Privacy Practice notice provided to me by Nashville Skin & Cancer. I understand that this notice will be in effect until further notice from Nashville Skin & Cancer.

Signature:_____ Date:_____

AUTHORIZATION TO OBTAIN OUTSIDE MEDICAL RECORDS

Nashville Skin and Cancer has my authorization to request my Protected Health Information from another physician, hospital or other personnel involved with my care in order to facilitate my treatment.

Signature:_____ Date:_____

Responsible Party (Guarantor) Statement (if not the patient)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____/_____/_____ Gender: M F SSN _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Relationship to Patient: spouse child guardian other _____

Signature: _____ **Date:** _____