

WARREN DERMATOLOGY AND MOHS SURGERY, LLC

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment and/or copayments for services are due at the time services are rendered. We accept cash, checks and credit cards. We will be happy to help you process your insurance claim form and in some instances we accept assignment of insurance benefits. Some of our services are not covered under certain insurance plans. These services are then payable by you at the time of service. Please know your insurance coverage. Returned checks are subject to additional fees. We will gladly discuss and answer any questions relating to your insurance.

You must realize, however, that:

1. *Your insurance is a contract between you, your employer and the insurance company.*
2. *Our fees are considered to fall within the acceptable range by almost every insurance company, and therefore are covered up to the maximum allowance determined by each carrier.*
3. *Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

I hereby authorize payment directly to Warren Dermatology and Mohs Surgery, LLC for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

I hereby authorize Warren Dermatology and Mohs Surgery, LLC to release any information acquired in the course of my examination or treatment to my medical insurance carrier(s).

I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Warren Dermatology and Mohs Surgery, LLC.

I hereby authorize photocopies of this form to be valid as the original.

Date _____ Patient's Signature _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of Warren Dermatology and Mohs Surgery, LLC Practices.

OR

I, _____ have been offered a copy of Warren Dermatology and Mohs Surgery LLC Notice of Privacy Practices but do not wish to receive a copy at this time and will reserve the right to request a copy at a later date. A copy of the notice is posted in the waiting room for my convenience.

Print Name: _____

Signature: _____

Date: _____