AUSTIN DERMATOLOGY ASSOCIATES

POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

We accept certain insurance plans; therefore please provide us with your insurance card. We will let you know if your plan is one for which we are a designated provider. If you wish to be seen at Austin Dermatology Associates, you are responsible for payment of all co-pays and or deductible charges at the time of service. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service.

Please remember that insurance policies may not cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or talk with an insurance representative.

Some procedures performed at Austin Dermatology Associates are considered cosmetic and will not be covered by insurance. Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

We accept payment in the form of cash, check, credit or debit card. Any checks returned to us due to insufficient funds will result in a fee of $25.00 each.

There will be a $25.00 charge for missed appointments not cancelled 24 hours prior to your appointment time and for changes made to an appointment without informing our office beforehand.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided by Austin Dermatology Associates, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

_________________________________ _____________________

Signature of Patient/ Responsible Party Date

HIPAA PRIVACY PRACTICES

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a section concerning Patient Rights under the law. The Notice is available to you at the front desk at your request. You may review the Notice before signing this consent. The patient has the right to restrict the uses of their information.

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature.

_________________________________ _____________________

Signature of Patient/ Responsible Party Date

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