Cahaba Dermatology
skin health center

**Patient Consent to Treatment & Financial Responsibility**

I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize an examination by my doctor and such assistant or staff as may be assigned by the physician. I authorize Cahaba Dermatology & Skin Health Center, LLC to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. We have contracts with many insurance companies to accept assignment of benefits for our services. In order to do this we must have a valid insurance card and a driver's license or other legal form of identification at the time of the visit or you will be charged as a private pay patient and charges for your visit will be your complete responsibility. You are responsible for knowing your insurance coverage and benefits. Insurance coverage varies from plan to plan. Cahaba Dermatology will not waive your financial responsibly if your insurance provider denies payment. Your co-pay and any deductible are expected at the time of service. We accept Cash, Check, Credit Card and Care Credit.

As a service to you, we will file your insurance claim. You will be billed for any amount not covered by the insurance company, including deductibles, surgical/pathology deductibles and co-insurance. Payment is due upon receipt of your statement. For cosmetic services not covered by health insurance, charges are payable on or before the day service. Photography is at times a necessary part of planning and evaluating treatment. Patient or responsible party authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed. Cahaba Dermatology shall be entitled to recover any losses or damages it may suffer by reason of a failure of the patient and/or responsible party to pay charges when they become due, including, but not limited to, reasonable attorney fees, plus costs of enforcing this agreement. Any amounts overdue for more than thirty (30) days shall accrue interest at the rate of 1.5% per month. Balances delinquent more than 90 days are subject to collection efforts and associated reporting to collection agencies. Patient will be responsible to pay Cahaba Dermatology for fee's charged by assigned collection agency.

I authorize that payment of Medicare or other commercial insurance company benefits be made to Cahaba Dermatology & Skin Health Center, LLC for services provided.

I authorize the release of any information needed for processing of this or any related claim/s. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment. A copy of this authorization shall be considered as valid as the original. I acknowledge I have read this information thoroughly and understand this patient financial responsibility form.

If it becomes necessary to cancel or change your appointment, we require at least 24 hours advanced notice. This is important so that we may offer appointment time to another patient in need of seeing the doctor. If an appointment is cancelled or changed with less than 24 hours' notice, there will be a $50 cancellation fee applied to account. Fee is $100 fee for surgical appointment. These fees will also be applied to patients account for any appointment no-show. These fees will be the responsibility of patient or party financially responsible for patient.

Your signature below conveys your understanding of terms and acceptance of financial responsibilities outlined.

Signature:_____ Date: _____

Relationship to the patient (If other than patient)_____