Anderson and Rahman
DERMATOLOGY

PATIENT NAME: _____ DOB: _____

LAB/BIOPSY RESULTS: I authorize the staff of Anderson and Rahman Dermatology, PLLC to notify me of my ***normal*** labs and/or ***benign*** biopsy results via (*check all that apply*):

☐ Voicemail of primary phone number ☐ HIPAA Contact ☐ Do not leave message

HIPAA CONSENT: AUTHORIZATION TO REVEAL MEDICAL AND BILLING INFORMATION

I authorize Anderson and Rahman Dermatology, PLLC 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, Anderson and Rahman Dermatology, PLLC will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Anderson and Rahman Dermatology, PLLC.

Name: _____ Relationship: _____

NO SHOW POLICY: Our physicians and staff work very hard to meet the needs of our patients. We kindly ask that you give **24-hour notice** if you need to cancel your appointment. As a courtesy, we attempt to make confirmation calls 48 hours in advance of your scheduled appointment, and we will attempt to leave a reminder message on your answering machine if there is no answer. However, you are responsible for notifying us if you will not be able to make it. A one time consideration will be made for failure to show up for your appointment. Any no shows thereafter will be charged as follows:

- Routine office appointments: $20
- Cosmetic appointments: $75
- Surgeries: $100

Payment must be made before another appointment may be scheduled. Thank you for your understanding in this matter.

FINANCIAL POLICY: We have contracts with many insurance companies to accept assignment of benefits for our services, but we must have a valid insurance card on file in order to do this. If you cannot present a valid insurance card at the time of the visit, you will be charged as a private-pay patient You are responsible for knowing your insurance. **Your co-pay is expected at the time of your visit**. As a service to you we will file your insurance claim following your visit. 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.

I understand that each time I am seen in the office for evaluation and/or treatment, an office visit can be charged in addition to any other charges. We accept cash, check, Visa, MasterCard, and Discover. I request that payment of Medicare or other insurance company benefits be made to Anderson and Rahman Dermatology, PLLC for services provided. I authorize the release of any information needed for processing of this or and 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.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given the Notice of Privacy Practices for Anderson and Rahman Dermatology, PLLC and understand the policies. I am aware that I may request a copy at any time.

SIGNATURE: _____ DATE: _____
(patient or guardian)