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**PATIENT AGREEMENT**

**By signing this document, you acknowledge that you have read and consent to the terms outlined below.**

* **RELEASE OF INFORMATION**:

I authorize the release of medical information to my primary care physician, referring physician and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

* **RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I have received and/or reviewed a copy of LARK Dermatology’s Notice of Privacy Practices.

* **FINANCIAL POLICY:**

I have reviewed the Financial Policy and consent to the terms which include but is not limited to the following:

* We require co-pays are paid in full at the time of service.
* **If your deductible has not been satisfied, we will estimate the cost of services and require 50% payment at time of service. The remaining balance will be billed to the credit card on file per our credit card on file policy.**
* **CREDIT CARD ON FILE POLICY:**

I have read and consent to the terms outlined in the Credit Card on File Policy.

* **CANCELATION/NO SHOW POLICY**:

I am aware that there will be a fee of $50 for appointments that are missed, cancelled or rescheduled without 24-hour notice and that if I miss two appointments, I may be moved to walk-in status.

* **MESSAGES / FOLLOW-UP COMMUNICATIONS:**

I give permission to leave a message on the cell number I provided.

**MEDICARE PATIENTS ONLY:**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim.

By signing, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”,

By signing, I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

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Name of Patient

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Name of Responsible Party

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Signature of Patient or Responsible Party Date

FOR OFFICE USE ONLY IF PATIENT REFUSES TO SIGN: I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

□ Patient Refused to sign □ Communications barriers □ Emergency situation □ Other (explain)

Office Employee Signature: Date: