In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, a collection fee of 33 1/3% of the outstanding amount will be added to your account. In the event that an appointment is not cancelled within 24 hours, you will be charged a $25.00 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ____ **Date** _____/_____/_____

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).
I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.
A copy of this authorization may be used in the place of the original.
I understand and agree that I am financially responsible for all charges not paid by my insurance company. This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature ____ **Date** _____/_____/_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

Dermatology Associates of Northern Virginia may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations.

Dermatology Associates of Northern Virginia may mail to my home or other designated locations any items that assist the practice in carrying out treatment, payment or other healthcare operations.

By signing this form, I am consenting to Dermatology Associates of Northern Virginia's use and disclosure of my protected health information to carry out treatment, payment and other healthcare operations.

____
Signature of Patient or Legal Guardian

____ ______________________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian