VIRGINIAdermatology
& skin cancer center

Acknowledgement of Receipt of Notices of Privacy Practices

Thank you for choosing Virginia Dermatology and Skin Cancer Center for your dermatologic healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided a copy of our Notice.

_____ _____
Signature of Patient (or Legal Representative) Date

_____ _____
Staff Signature Date

PATIENT FINANCIAL POLICY

This office has contracts with Medicare and with many managed care plans. Please check with our staff to determine whether your plan is one of these.

If the office has a contract with your plan, then a claim will be filed with your insurance company. The amount for which you are responsible (any deductibles, co-pays, percentages or non-covered services) is required at the time of service.

If at any time you are concerned about the cost of a procedure proposed, you may ask for someone from the billing representative, discuss the cost with you.

For your payment convenience this office accepts Care Credit, MasterCard, American Express, and Visa in addition to cash and checks.

Because we make every effort to see patients on time, we do not overbook to accommodate patients who do not keep their appointments. Therefore, this practice charges a $75.00 fee for missed appointments not cancelled with at least one business day advanced notice.

I certify that I have read the financial policy of Virginia Dermatology and Skin Cancer Center, and agree to abide by the policy.

_____ _____
Signature of Patient (or Legal Representative) Date

TERMS OF INSURANCE

MEDICARE POLICY HOLDERS

I, Authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid 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 that accepts assignment. Regulations pertaining to Medicare assignment benefits apply.

_____ _____
Signature of Patient (or Legal Representative) Date

ALL INSURANCE POLICIES EXCLUDING MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Virginia Dermatology and Skin Cancer Center. Also to provide my insurance company any information necessary to process claims for services rendered to me.

_____ _____
Signature of Patient (or Legal Representative) Date