Venice Avenue Dermatology

Consent for Treatment, Exposure policy, and Fee Responsibility

This is to certify that I (or my authorized agent) consent to the performing of any surgical or medical procedure or examination as required. I (or my authorized agent) assume financial responsibility for any services rendered.

If another person is exposed to my blood or bodily fluids, I consent to have my blood drawn and tested and to the disclosure of my results to Venice Avenue Dermatology and the exposed person for the purposes of treatment of the exposed person.

We may use your health information and/or records to:

- Plan for your care and help your health care providers communicate and work together for your medical benefit
- Submit bills for reimbursement for the care provided to you
- Help health care payers or medical insurance companies verify that services were provided to you
- Help improve the quality of your health care
- Disclose information to certain officials or organizations as requested by law

Everyone at Venice Avenue Dermatology is bound by law to uphold all privacy standards. We encourage you to read the Notice of Privacy Practices and ask us any questions. This authorization may be revoked at any time to the extent that use or disclosure has not already occurred prior to your request. To update or revoke the authorization, notify the Venice Avenue Dermatology Privacy Officer in writing or call (941)-486-1404.

By signing below, you confirm that you have read and understand your rights to privacy, and that you have been given access to all information pertaining to those rights.

Signature: ______________________________ Name: ______________________ Date: ______________________

() Patient () Parent () Legal Guardian

Venice Avenue Dermatology will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this Authorization. The Protected Health Information disclosed as a result of this authorization may be redisclosed by the entity receiving it, and thus is no longer protected by the federal privacy regulations. This Authorization is given without promise of compensation. The patient and, if applicable, parent/legal guardian release to Venice Avenue Dermatology any right, titles and/or interest of any kind they may have in the information produced.
The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If Venice Avenue Dermatology requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Venice Avenue Dermatology is a division of Premier Dermatology LLC. Your financial statements and billing related correspondence will come from Premier Dermatology LLC. If at any time you have questions regarding your bill for services performed at Venice Avenue Dermatology or by our pathology laboratory, please contact our Central Billing Office at (941) 312-5027 for assistance.

Insurance Information – If Card(s) Are Not Available			
Primary Insurance:		**Secondary Insurance:**	
Member ID #:	**Group #:**	**Member ID #:**	**Group #:**
Subscriber's Name:		**Subscriber's Name:**	
Subscriber's DOB:	**SS #:**	**Subscriber's DOB:**	**SS #:**
Subscriber Relationship to patient:		**Subscriber Relationship to patient:**	

Financial Policy, Notice of Privacy Practices, Authorization, and Payment Terms

We ask that you read and sign the following form to acknowledge your financial responsibility for the medical services provided here as well as our policy on the protection of your private health information. We will be happy to provide further clarification if necessary. In order to avoid any misunderstanding regarding our payment policies, please review our Financial Policy below.

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, deductibles, and co-insurance will be collected at the time of service.

We accept payment via cash, check, debit cards, Master Card, Visa, Discover, and American Express.

We may request a payment authorization form to be filled out at the time of check-in for patients who are minor, uninsured or with an outstanding balance, as well as patients with a non-participating insurance (including non-QMB Medicaid patients). Any outstanding balance from your visit will be mailed to your primary address. If there is any discrepancy or if you are unable to pay the balance in full, we ask that you contact our office immediately. Failure to settle your balance will result in further collection efforts and a collection fee may be assessed to your account.

Please note that you may be billed separately for laboratory analysis if we are required to send specimens (such as a biopsy) to an external laboratory. Ask us if any specimen was submitted to an external laboratory at time of checkout.

Participating Insurance: We are a provider for a variety of commercial insurance carriers and we bill them as a courtesy to you. Prior to your visit, you will be informed whether or not we are a provider for your insurance plan. We accept payment for covered services from these insurance plans in accordance with our contracts. It is your responsibility to know and understand the guidelines of your insurance plan. You should attempt to seek medical care with physicians participating in your plan when possible. Insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy or talk with your insurance representative. **You are responsible for co-insurance, deductible amounts, and payment for services not covered by your insurance at the time of service.**

Medicare Patients: We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. **We do not bill supplemental insurance carriers.** If your secondary insurance does not crossover with Medicare, you are responsible for that portion of your charges at the time of service (normally 20% of the covered charges).

Medicaid Patients: We are not a Medicaid provider. If you are not a Qualified Medicare Beneficiary you are responsible for payment of all charges non-covered by Medicare at the time of service.

Uninsured & Non-participating Insurance: If we are not a provider for your insurance you are responsible for payment of all charges at the time of service. For non-participating insurance, we will provide you with a receipt for reimbursement.

Refund Policy: We do not offer refunds for medical and cosmetic procedures. Product returns are limited to company policy.

I voluntarily consent to care treatment by Venice Avenue Dermatology including diagnostic procedures, labs and medical treatment ordered by the attending physician/ARNP/PA-C. I understand that I have financial responsibility for payment of medical services provided and hereby assume payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office. Additionally, in the event of non-payment, the undersigned guarantees payment of all costs of collections, including reasonable late fees and attorney's fees.

I have read and understand this financial policy and notice of privacy practices and agree to accept responsibility as described.

Patient/POA/Guardian: Signature:____________________________ **Date:** ________________

Printed Name (if not patient):____________________ **Relationship (if not patient):**________________

Patient Name: ____________________________ Date of Birth: ____________