Dermatology Associates of Central Florida, 3670 Innovation Drive Lakeland, FL 33812
Annual Financial & Privacy Agreement

Name: _____

Date of Birth: _____

Financial Policy: Payment in full is required at the time services are rendered, unless you are currently enrolled and eligible under one of the Insurance plans that lists this office as a participating network provider. Please check with your insurance company to verify this information. Please understand health plans have different copays, deductibles and rules and regulations regarding allowed visits for certain services. If our office participates with your health plan, we will honor the applicable fee schedules and discounts. You will be responsible for your co-payments, any co-insurances and applicable deductible amounts.

If our office does not participate with your health plan, payment in full is due at the time you exit our office for the services rendered to you.

Our office accepts payment by: cash, check, money order, debit card, Visa, MasterCard, or Discover. There will be a $25.00 fee assessed on all returned checks. As a courtesy to you, a claim is submitted to your insurance plan on your behalf. Once your insurance company considers your claim, if you still owe a balance after their decision, a statement will be sent to you. Our billing office will send three statements and one delinquency notice to you.

If you neglect to pay your bill, or you refuse to make payment arrangements, Your account will be forwarded to a collection agency.

I acknowledge that it is the policy of this office that payment is required at the time of service. An insurance claim submission on my behalf is a courtesy extended to me, or the party I represent, unless mandated by the health plan. I am financially responsible for all services not covered by my health plan.

Patient Payment Authorization:

I hereby authorize my insurance company (or Medicare) to send all payments for medical services rendered to me (or my dependents) directly to: Dermatology Associates of Central Florida. With my signature, I confirm the above demographic and insurance information is true and correct, and for any future services this authorization applies to. If the information is found to be inaccurate, I agree to be personally responsible for payment in full for the services provided. I further authorize the release of any information (including medical information) to my insurance company in order to determine the insurance benefits for which I may be entitled to.

Laboratory/Biopsy Services:

We provide the professional services portions for these procedures. If a specimen is sent to an outside source to confirm a diagnosis, you will be billed separately by the laboratory that provides the service.

NOTICE OF PRIVACY PRACTICES/ RELEASE OF MEDICAL INFORMATION: Our HIPAA Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. The Notice contains a patient rights section describing your rights under the law.

You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this consent, you specifically authorize our use and disclosure of protected health information about you for treatment, payment or health care operations, and as otherwise explained in the Notice of Privacy Practices. You specifically authorize the use and release of all of your health care information including, but not limited to mental health, HIV/AIDS, genetic testing, venereal disease, substance abuse, and tuberculosis information for treatment, payment, health care operations, and as otherwise permitted by law. Your information may be exchanged electronically.

I acknowledge that I have reviewed:

Financial Policy
Patient Payment Authorization
Laboratory/Biopsy Services
Notice of Privacy Practices/Release of Medical Information
for Dermatology Associates of Central Florida.
(Copy of Privacy Practice is available upon request)

X _____
Patient Signature (or representative)

___/___/_____ _____
Date Relationship if not patient

Do we have your Permission to:

Leave a message at your home number: **Y N**
Leave a message at your work number? **Y N**
Discuss patient's treatment with a family member? **Y N**

If Yes, Whom? _____

Office Use Only:

_____
Staff Signature Date

_____
Printed Staff Name

Insurance Verified/Current Card On File _____
Initial