ADVANCED DERMATOLOGIC SURGERY, P.A.

Financial/Fee Responsibility and Release to File Insurance Claims

If you provide us with accurate information, we will file insurance claims on your behalf, however, please remember that **you** are ultimately responsible for payment of fees according to your insurance contract. In order to control the cost of billing, **CO-PAYMENTS, DEDUCTIBLES AND FEES FOR NON-COVERED SERVICES ARE TO BE PAID AT THE TIME OF SERVICE.** We reserve the right to limit non-emergent medical care if you disregard your financial responsibility by ignoring our attempts at collection. We are happy to work with you to settle accounts; however, if necessary, we may utilize an outside collection agency and may report any (undisputed) unpaid balances to the credit bureaus.

To the best of my knowledge, my disclosed health information is accurate to date. I authorize the release of protected health information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable, including Medicare, private insurance, managed care plans, or any other insurance to Advanced Dermatologic Surgery, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am ultimately financially responsible for all fees whether or not covered by said insurance, pursuant to any agreements within my specific insurance contract.

* _____
Printed Patient Name

* _____ _____
Patient's Signature or Legal Representative Date