Albemarle Dermatology Associates, LLC

Financial Responsibility, Assignment of Benefits, and Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Options

I, ____________________________, hereby give my consent for Albemarle Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) (Albemarle Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have a right to review the Notice of Privacy Practices prior to signing this consent. Albemarle Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Albemarle Dermatology Privacy Officer at 3350 Berkmar Drive, Charlottesville, VA 22901.

I have the right to request that Albemarle Dermatology restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Albemarle Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Albemarle Dermatology may decline to provide treatment on me.

Statement of Financial Responsibility

I understand that payment is due at the time of service. I authorize the release of any information necessary for filing a claim for payment with my insurance company of record, and I will advise Albemarle Dermatology Associates, LLC of any changes in insurance coverage. I understand that any care not paid for by my existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial. Outstanding debt past 120 days will be referred to a collection agency; in this event, I agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs. There will be a fee of $25 charged by Albemarle Dermatology Associates, LLC for each check returned to the office by my bank.

Missed Appointment Fee

I understand that if I do not appear for a scheduled appointment, or cancel an appointment with less than 24 hours notice, I may be charged a fee of $25 for an office appointment or $50 for a missed surgery appointment.

Statement to permit payment of Medicare/Medicaid benefits to provider

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Albemarle Dermatology Associates, LLC for any services furnished to me by the provider. I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated, my signature authorizes the release of all information necessary to the insurer or agency to adjudicate the claim. In Medicare/Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge and that I am responsible for the deductible, co-insurance, and any non-covered services.

Statement to permit assignment of insurance benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, or any other health plans, to Albemarle Dermatology Associates, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy or scanned image of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not the charges are paid by said insurance.

I have read, fully understand, and accept the terms of this consent.

Signature: ______________________________________ Date: ____________________________