Acknowledgement of Receipt of Notice - Patient Privacy

DERMATOLOGY CENTER PC
40 Cross Street, Suite 340
Norwalk, CT 06851
Privacy Office (203) 847-1500

Name of Patient: _____ Date of Birth:_____

I hereby acknowledge that I received a copy of the Dermatology Center PC Notice of Privacy Practices.

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Insurance Plan _____ ID# _____ Medicare # (if applicable)_____

____I authorize my physician or designated staff to leave messages (voice mail and/or text) on my designated telephone number(s) and/or my e-mail.

____I authorize the release to my managed care program or designated health insurance company and its agents any information needed or appropriate to determining those benefits or the benefits payable for related services.

____I understand that copayments are due at the time of service. This is a contractual requirement between you and your insurance company. Patients who do not have their copayments will have to reschedule their appointment.

____If I do not have insurance, fail to produce my insurance card or I have insurance but with an insurance company or plan that Dermatology Center PC does not participate in, I understand that I am responsible for full payment at the time of service. Cosmetic procedures and products are not covered by insurance and must be paid for at the time of service.

____I understand that I am responsible for any deductible or other fees as specified by my insurance plan and it is my responsibility to know this information as well as what my plan covers. I understand that I will be billed promptly after a determination by my insurance plan that I am responsible for a deductible and/or other fees and I agree to provide prompt payment to the Dermatology Center PC.

____ I acknowledge and agree that if I do not provide prompt payment of any outstanding amount billed and due to the Dermatology Center PC, my account may be placed for collection. In the event my account is turned over for collection, I acknowledge and agree that I am financially responsible for the outstanding balance, plus a 15% collection fee and all attorney fees and courts costs that may be necessary or appropriate for recovery of the full amount due. All amounts billed and due to the Dermatology Center PC, plus costs of collection, if applicable, are expected to be paid prior to new appointments being scheduled.

_____I acknowledge and agree that I will be charged a $25.00 fee for returned checks.

____ I acknowledge and agree that in the event of a cancelled or missed appointment without at least 24 hours notice, I will be charged $50, which amount is expected to be paid prior to new appointments being scheduled.

____I authorized any holder of Medicare information about me to release to the Center for Medicare and Medicaid Services (CMMS) and its agents any information needed to determine those benefits or the benefit payable for related services.

Signed: _____ Date: _____

Print Name: _____ Telephone: H_____ C_____

***For Office Use Only*:**

- ❑ Signed form received by: _____