MD | MOORE DERMATOLOGY ASSOCIATES

# AUTHORIZATION/FINANCIAL AGREEMENT

I authorize the release of medical information to my primary care physician, referring physician, or consulting physician, needed to process insurance claims, insurance application and prescriptions.

I authorize payment of medical benefits for services rendered to the provider.

I authorize the use of this signature on all insurance submissions.

I understand that payment is required for all services at the time they are rendered unless I am in an insurance plan in which the practice participates. For those patients, I understand that my insurance will be billed for today's service. However, any copays due will be collected prior to seeing the provider. I understand that I am fully financially responsible for all charges not covered or denied by my insurance plan. Payment is expected within 30 days of the date of service. If payment is not received within 30 days of the date of service, a service charge may be applied.

I understand that payment is expected and appreciated at the time of service. Failure to pay the bill, will result in additional fees for collection agency or attorney costs. **The doctors reserve the right to refuse to see a patient whose account has been sent to collections for non-payment. In order for the doctors to see the patient, the patient must pay their past due amount to the collections company that currently holds their account.** We appreciate your understanding.

I understand that if my account is turned over to collections for non-payment, an additional **$30.00 collection fee** will be added to my account.

I understand there will be a **$25.00 fee** charged for checks returned for insufficient funds.

I understand any procedure performed in the office may be billed separately in addition to the office visit fee.

I understand that any request by the patient for copies of medical records will incur a handling & copying fee within the Illinois statute.

I authorize (by supplying my home phone number, mobile phone number, email address and any other personal contact information) my health care provider to employ a third-party automated-outreach-program to use the name of my dermatology care provider, the time and place of my scheduled appointment and other limited information for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam or balance due.

I consent to the receiving of an email reminder of my appointment, a text message reminder of my appointment and a message about my appointment being left on my voicemail, answering machine or with another individual, if I am unavailable at the number provided by me. This will only be notification of the provider, day, time and location of your appointment. No other information, such as what the appointment is for, will be given out.

I authorize and give my permission to receive emails and/or mailing specials from Moore Dermatology.

I understand that I am responsible for notifying the office 24 hours in advance to cancel an appointment. Otherwise, I will be responsible and billed for a **$25.00 No Show Fee.**

I understand that there may be an out of pocket fee if the doctors/physician assistant are paged after hours, and if a response is required by the doctor/physician assistant to an email or text, and for a refill of a medication if the patient has not been seen recently.

I acknowledge that I have been offered and reviewed this office's Notice of Privacy Practices (HIPAA).

Patient Name (please print): _____

Patient Signature (for patients age 18 or over): _____Date: _____

Signature of Parent/Guardian/Legal Representative: _____ Date: _____