Mary T. Pentel, M.D.

GENERAL POLICY STATEMENT

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by the clinic. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due at the time of service, unless other financial arrangements are made. This includes deductibles, co-pays, and/or co-insurances. Established patients with a delinquent balance will be asked for payment at the time of service.

I assign Southside Dermatology all payment to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

For cosmetic procedures and skin care products, payment in full is expected at the time of each visit. Skin care products are non-refundable.

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral from your primary care provider (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment.

Insurance Billings: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit. Charges owed due to errors, claim rejections, and/or non-response by the insurance company are the responsibility of the patient.

Medicare: Our physicians are participating providers. Although we bill Medicare as your primary insurer, you may be responsible for billing your supplemental insurance. I understand that I will be responsible for any portion determined by Medicare as "patient responsible" and any charges not covered by Medicare will be my responsibility.

Check Returns: It is our office policy to charge all patients a $30.00 fee for checks that are returned.

Cancellation: A $20.00 fee will be charged for any appointment cancelled without 24 hours notice.

Authorization to Release Information: I have read and I accept this policy for my testing and/or treatment with Southside Dermatology. The Notice of Privacy Practices for Southside Dermatology is prominently displayed in the clinic waiting room and I acknowledge I have seen a copy of the Notice of Privacy Practices.

I, or my appointed agent, have read, fully understand and agree to the above statements.

_____ _____ _____
Patient Name (print) Patient's Signature Date

IF THE PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING

Patient is _____ year(s) of age or is unable to sign because:_____

_____ _____ _____
Signature Relationship to the Patient Date

Sign below if disclosure of information is not authorized:
Therefore, I agree to pay for costs of all treatment and services personally.

_____ _____ _____ _____
Signature of Guarantor Date Signature of Patient Date