beacon
skin & surgeries
DERMATOLOGY

PATIENT CONSENT TO TREATMENT AND AGREEMENT TO FINANCIAL POLICIES

Beacon Skin & Surgeries (referred to herein as "Beacon Skin & Surgeries" "we," "us," and/or "our") maintains the policies below. By signing this consent, you agree to receive medical care and treatment from Beacon Skin & Surgeries and its employed, contracted, and affiliated healthcare providers and you authorize Beacon Skin & Surgeries to coordinate with your other healthcare providers on your behalf. You hereby agree that we will not be liable for any failure to provide, or delay in providing, services to you in the event that we are assisting another patient(s) in an emergency or in the event of other circumstances beyond our reasonable control. In the event of an emergency, or a situation in which you could reasonably expect an emergency to arise, you agree to call 911 or visit the nearest emergency room and follow the directions of emergency personnel.

BILLING: You must present current valid insurance information at each visit with us. If you have not provided your current valid insurance card and any referrals required by your insurance, you may be asked to reschedule your appointment or to pay for your visit on the same date of service. **It is your responsibility to understand your insurance benefits including, without limitation, your copays, coverage and deductibles, and any required referrals.** You understand that if no insurance coverage exists for any services or products that you receive from Beacon Skin or your insurance provider(s) fails to pay Beacon Skin, then you are financially responsible for the incurred charges.

If the services or products provided by Beacon Skin & Surgeries are payable under an applicable insurance benefit, you hereby assign all insurance payments and medical benefits directly to Beacon Skin & Surgeries for the services rendered and products provided by Beacon Skin & Surgeries. You understand that this Policy imposes no obligation for Beacon Skin & Surgeries to collect money on your behalf. Any deductibles or copays owed to Beacon Skin & Surgeries pursuant to your insurance policy will not be waived. **Copays will be collected at check-in prior to every visit. If you have a deductible, $50 toward your deductible for office visits and $100 toward your deductible for surgery appointments will be collected at check-in prior to every visit.**

Beacon Skin & Surgeries maintains a standard fee schedule, subject to change from time to time, which we would be happy to discuss at any time. You agree that you are financially responsible for and will pay all incurred charges for all services and products provided by Beacon Skin & Surgeries and its employees, contractors and providers. **Payment is due within 60 days of the first statement date after which time a late fee of $35 will be assessed.** You understand that Beacon Skin & Surgeries has the right to forward unpaid accounts to a collections agency and you agree to bear and reimburse Beacon Skin & Surgeries for all costs associated with collection efforts on your account.

LAB or PATHOLOGY BILLING: You agree that, in the event that any of your specimens are sent to a laboratory by us, you will be directly billed by that laboratory, and you will be solely responsible for paying that laboratory for all laboratory and related interpretation services performed regarding your specimen(s). Specimens may include, but are not limited to: skin biopsies, microbiology cultures/tests, and molecular studies. If you have questions regarding the lab your specimen/test is being sent to, please discuss with your provider BEFORE the procedure/test is done.

REFUNDS: You agree that if any refund is due to you, that **the amount will be refunded back to the original form of payment if paid by credit card.** The refund will show up on your credit card statement.

NO SHOW POLICY: A "no show" is someone who misses an appointment without canceling within 24 hours of the appointment. **Patients who are no-shows will be charged a $50.00 no-show fee for routine appointments and $100 for Mohs Surgery appointments.** Patients who have 3 no-show appointments within 1 year will be subject to administrative dismissal from the practice.

Your signature below evidences your agreement to all the terms as set forth in this document and that you are the patient or are authorized to act on behalf of the patient to sign this consent.

Patient Name: _____ Patient DOB: _____

Alternative Consent Authority & Signature -- Patient's Parent or Guardian Name:
Relation: _____ *Printed Name:* _____

Patient / Agent / Guardian Signature: _____ Date: _____