Peraza Dermatology Group

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POLICY CONSENT FORM

The following is a summary of our office policies. Some policies may not pertain to your treatment today, but may apply to future visits, treatments or procedures. Please review and sign below.

- **Prescription Refill Policy**: Our physicians normally prescribe sufficient refills to last patients until their next follow-up appointment. If you, the patient, need a refill and do not have a scheduled appointment, please call our prescription line at 603.542.6455. The physician will review the request. If the patient needs to be seen prior to a refill, our staff will call to schedule an appointment. Otherwise, please allow our office 72 hours to process your request.
- **Cancellations and No-Shows**: Our office attempts to contact all patients prior to scheduled appointments. If the patient is unable to keep an appointment, we kindly ask that you provide us with 48 hours notice. A $50.00 no show/cancellation fee will be applied to all patient accounts when an appointment is not cancelled at least 24 hours prior to the scheduled appointment. This courtesy makes it possible to give appointments to other patients. Patients must cancel all cosmetic appointments 48 hours prior to ones scheduled appointment to receive refund of deposit.
- **Payment Options (*for procedures not covered by insurance*):** Cash, Check, VISA, Mastercard, Discover, Debit Cards, Money Orders or Cashiers Checks.
- **All cosmetic and private pay fees are due at the time of service**. **A $100.00, non-refundable deposit is required for all scheduled cosmetic procedures. This deposit will be applied to your service on the day of treatment.**
- Peraza Dermatology Group and the front desk staff will not be able to quote exact prices prior to your appointment.
- **Required Payments at Your Visit:** Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service. It is the patient's responsibility to check these conditions prior to their appointment and bring an approved method of payment, as listed in the payment options section. The appointment will be cancelled and rescheduled if you, the patient, do not bring appropriate means of payment.
- **Regarding Insurance:** Peraza Dermatology will file claims directly with the patient's insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee the patient's insurance will pay for services. It is the patient's responsibility to know if our physicians are considered "in-network" by the patient's insurance. Payment is due within 30 days of receipt of a statement sent from our office.
- **Payment Plans**: In special circumstances, Peraza Dermatology will offer payment plans to those who are unable to pay their balance in one full payment.
- **Authorizations and/or Referrals:** Authorizations/referrals are an arrangement between patients and their insurance carrier. Authorizations/referrals are required prior to treatment. It is the patient's responsibility to bring a copy of their authorization/referral from their primary care doctor to our office. If a patient does not bring their authorization/referral with them, then their appointment will be cancelled and the patient will have to reschedule or be seen as a self-pay patient.
- Minors under the age of 18 will receive medical care and/or treatment with a parent, legal guardian or an authorized accompanying adult only. Minors under 18 who are unaccompanied, will not be seen.
- Some surgical pathology and other lab specimens are submitted to outside laboratories for analysis and or slide preparation. These services represent an additional fee charged to you by an outside office. Second opinions are obtained when the physician feels it is necessary to provide optimal care.
    - As a patient, you understand that you may receive a separate bill from an outside hospital facility or laboratory such as: Mid Atlantic, DHMC, Borstings Laboratory, Quest, etc.

By signing this I acknowledge that a copy of Peraza Dermatology Group's Notice of Privacy Policies has been made available to me.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ _____ /_____ /_____
Signature Date

Relationship to Patient
(if other than patient): _____