COSULICH DERMATOLOGY, LLC

FINANCIAL POLICY

Welcome to Cosulich Dermatology, LLC, where we are fully committed to giving you the best care possible. We thank you for choosing our practice as your dermatology specialist. Please continue reading and sign below to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies.

Authorization for Treatment and Payment of Medical Benefits

I give permission to Cosulich Dermatology, LLC to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography

I agree that any photo identification and photos of spot and lesion sites taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of my treatment and medical care.

e-Prescription Consent for Medication History

We may request and use your prescription medication history information from your pharmacy using our e−prescription feature. This is only for informational purposes so that an up−to−date record of your medication is available for your treatment and safety.

- ◯ Yes, I consent to obtain my medication history using the e−Prescribing feature.
- ◯ No, I do not consent. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian) understand that I am ultimately responsible for the payment of my treatment and care, including Lab/Pathology fees, which are separate from normal Practice fees.
- Cosulich Dermatology will assist me by billing my contracted insurers. However, I understand that I am required to provide the office with the most correct and updated information for my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated. I understand that if I need a referral, it is my responsibility to contact my primary doctor for the referral prior to my Cosulich Dermatology appointment. I understand that any bills resulting from not obtaining the required referral are my responsibility as the patient.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand payment is due at the time of service, payable by cash, check, and most major credit cards, including HSA and FSA cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include, but are not limited to:
    - Charge for returned checks
    - Charge for the copying and distribution of patient medical records
    - Charge for forms the practice fills out on your behalf
    - Charge for missed appointments

Patient Authorizations

I hereby authorize Cosulich Dermatology, LLC to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services. I hereby authorize assignment of financial benefits directly to Cosulich Dermatology, LLC. I understand that I am financially responsible for charges not covered or denied, in full or in part, by my insurance plans.

Print Name:_____ Signature:_____ Date: _____