<u>Atlantic Shore Dermatology Payment Policy</u> Chart # ___________

NOTICE OF PRIVACY PRACTICES
By signing below, I acknowledge that I have been provided with the above practice's Notice of Privacy Practices to review.

AUTHORIZATION FOR SERVICES
The signature below servers as authorization for services rendered by Ashley C. Cavalier, M.D. for the above named patient, and release of information necessary to file insurance and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. A copy of the signature is as valid as original.

AUTHORIZATION FOR RELEASE OF INFORMATION
The signature below serves as authorization for Ashley C. Cavalier, M.D. to release or receive all medical information for the purpose of patient referral or treatment of and including treatment of workman's compensation injures. A copy of this signature is as valid as the original.

PAYMENT POLICIES
We need your assistance and understanding of our payment policy. As a courtesy, Atlantic Shore Dermatology will bill most insurance. HOWEVER, the patient is responsible for any non-covered or unpaid balances *** ALSO ANY REFERAL NUMBERS OR AUTHORIZATIONS (EXAMPLE: TRICARE, PCN, ETC) NOT PROVIDED TO OUR OFFICE PRIOR TO APPOINTMENT *** Your insurance coverage is a contract between you and your insurance company All services are filed with your group insurance carrier providing you furnish all pertinent information to our office. Insurance co-payments and deductibles are expected when service is rendered, which includes any Office visits, Injections or Surgeries. We accept cash, personal checks, VISA, MasterCard and Discover. You will continue to receive a statement each month even though your insurance is pending. You may receive more than one bill from Atlantic Shore Dermatology.

I have read the above Payment Policy and understand that even with insurance coverage, including workmen's compensation <u>if charges are denied I am financially responsible for my charges incurred.</u> If I need to set up an extended payment arrangement, I will contact the Patient Account Department. If no payment has been received after 90 days from the date of service, necessary collection procedures will begin.

Or if, I am a private pay/Medicaid Patient:
I understand that The Provider at Atlantic Shore Dermatology is not participating with Medicaid. I am being accepted as a private pay patient and I will be responsible for paying for all services rendered. The provider will not file a claim to Medicaid for services provided to me.

By signing this form, I acknowledge, I have read and understand all of the above and agree to Atlantic Shore Dermatology's policies and practices.

Date_____________ Print Name________________________ Signature_________________________

****** Please print and retain a copy for your records ******