PINNACLE DERMATOLOGY
medical | surgical | cosmetic

Notice of Financial, Insurance, and Privacy Practices

All charges are expected to be paid in full unless prior arrangements have been made.

- **Insurance:** Your charges will be filed at your request, but you will be expected to pay your coinsurance and any deductible not met. If you have questions about your coverage, it is your responsibility to contact your insurance company before your appointment. You may be personally responsible for any charges not covered by your insurance.
- **Copays:** You will be expected to pay your insurance copay **every time** you see the doctor.
- Labs will be billed by Quest Diagnostics. Pathology will be billed separately by Prime Medical Group.
- **Uninsured Patients: YOU WILL BE EXPECTED TO PAY IN FULL AT TIME OF SERVICE.**
- You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.
- **Non-covered charges:** You will be responsible for all NON-COVERED charges (lab, procedures, etc.) not payable by your insurance company.
- **Financial Services:** Please refer all inquiries regarding this payment policy to the Receptionist prior to being seen by the doctor. The doctor is here to provide your medical care and the staff is here to help with your financial services.
- **Cosmetic Procedures or Products:** This will not be filed with your health insurance and is payable in full when services are rendered.
- **I fully understand the payment policy as stated and agree to comply.** **Initial** _____

Acknowledgement of Receipt of Notice of Privacy Practices – HIPAA Regulations

By signing below, I acknowledge that I have been provided with the opportunity to review and obtain a written copy of the Pinnacle Dermatology Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at Pinnacle Dermatology where I receive health care services. **Initial** _____

IF YOU WOULD LIKE SOMEONE ELSE TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION ON YOUR ACCOUNT PLEASE LIST THEIR NAMES BELOW. I CONSENT TO ALLOW ACCESS TO THE FOLLOWING PEOPLE:

NAME	PHONE NUMBER	RELATIONSHIP

_____ ____/_____/____
Patient Name (PRINT) **Date of Birth**

_____ _____
Patient Signature (or authorized representative) **Date**

If you are not the patient, please fill out the following information:

Name: _____ Relationship to Patient: _____
Address: _____
Telephone: _(_____)_____

Please furnish a copy of any conservator/guardianship papers with this form.