PIERRE
SKIN CARE INSTITUTE

_____ If minor, name of parent/guardian: _____

PRINT Patient Name **PRINT parent/guardian**

I acknowledge that I have received a copy of the office **Notice of Privacy Practices**. The Notice explains how my protected health information is used and disclosed. _____ (Initials)

_____ (Initial) I grant permission to Pierre Skin Care Institute to send me a secured email, or leave a message regarding my condition and/or my bill on the phone numbers provided: Home _____, Cell_____

CANCELLATION POLICY

If I cannot make my scheduled appointment, I will make all reasonable attempts to cancel my appointment with an advance notice of at least 24 hours to allow another patient or patients to be scheduled in my appointment slot. If I fail to cancel my appointment with at least 24 hours advanced notice, I understand I may have to pay a $50 cancellation fee. I understand that this is not a fee that is billable to my insurance company.

I also understand that this policy is necessary due to the extended waiting time for appointments and the high cost of running this medical practice. Please be aware that we do not frivolously charge patients for missed appointments. If you have a legitimate reason for being unable to keep your appointment such as a death in the family or a medical illness, we accept these explanations. Our primary concern is for patients who forget their appointments, are too busy to keep their appointments or change their mind and fail to give us adequate time to fill their appointment slot with another patient. _____ (Initials)

FINANCIAL POLICY

As a courtesy, Pierre Skin Care Institute will bill your insurance company for your care provided you give us all the information we need. Even though you have insurance coverage, remember that paying for your treatment is your personal responsibility. You agree to give us permission to bill your insurance company on your behalf. If your insurance takes more than 60 days to respond to your claim, your services will be considered your financial responsibility at which time you may seek reimbursement from your insurance company if you wish to do so. Please remember to inform us of any changes to your insurance coverage.

All co-payments are due at the time of service. You are responsible for paying your portion of the charges as they are incurred. This includes the annual deductible, co-insurance, and charges not covered by your insurance company. While our office policy does not allow us to extend credit, we accept the following credit cards as forms of payment: American Express, Discover, MasterCard and VISA.

(Optional): For your convenience, you may complete this section to authorize Pierre Skin Care Institute to charge your credit card for any balances due after your insurance company has made payment to our office for services.

Name: _____ Card#: _____ Billing Zip Code:_____

Exp Date:_____ Signature: _____ Contact me before charging my credit card. Yes____ No____

Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and its attached stub. The information on the stub is very important. Also, your insurance company may request additional information from you. They will not pay your claim until they receive the information, so please send it immediately.

Payments are due upon receipt of the statement. After 30 days, you will be charged a $25 late fee. Accounts that are more than 90 days past due are transferred to an outside collection agency and expenses/fees will be added to your account balance. You agree to be liable for all such collection expense, legal fees and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $25

I have read and understand all the terms of this policy. By my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Patient Signature (Parent/guardian if patient is a minor) Date