Dermatology Services, Inc.
Skin Care Center

145 Faunce Corner Mall Road, North Dartmouth, MA 02747
Tel. 508-993-7601 Fax 508-997-0523

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Dermatology Services, Inc. (DSI). Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy upon request.

I acknowledge receipt of the Notice of Privacy Practices of DSI.

Signature of Patient/Legal Representative

Relationship to Patient (Legal Representative)

Print Name

Date

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment:

NAME	PHONE	RELATIONSHIP

I authorize DSI to leave messages on my voicemail/answering machine for:

- ☐ appointments DSI may schedule for me with other medical offices
- ☐ results from procedures and tests

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PAYMENTS / NO SHOW / CANCELLATION POLICIES

1. **Insurance.** We participate with most major insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payment and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment/deductible at each visit. If you are unable to pay at the time of service, your appointment may be rescheduled.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. **Proof of insurance.** All patients must complete our patient information forms before seeing the provider. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Insurance changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Divorce.** In case of divorce or separation, the party responsible for payment on the account is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We do not forward bills to other parties regardless of court rulings or divorce decrees.
8. **Returned Checks.** There is a $25 fee for any check returned by the bank.
9. **Non-payment.** If your account is over 90 days past due, we may refer your account to a collection agency and report it to the credit bureau.
10. **No Show/Cancellations.** If you must cancel or reschedule an appointment, we ask that you call as soon as you can, preferably at least 48 hours before your scheduled appointment time. Failing to show up for your appointment or cancelling less than 24 hours in advance (unless extenuating circumstances) are documented. After three "no shows," or "late cancellations" our policy is to discharge the patient from the practice.

I have read and understand the payment policy and agree to abide by its guidelines.

_____	_____
Patient/Guarantor Signature	Date
_____	_____
Patient Name (printed)	Patient Date of Birth