



DO WE HAVE PERMISSION TO: (Please circle your answer)

Leave a message on home answering machine: (example, to confirm appointment, lab results)	YES	NO	NA
Leave a message at your place of employment?	YES	NO	NA
Leave a message on your cell phone?	YES	NO	NA
Send an appointment reminder card to your home:	YES	NO	
Discuss your medical condition with any member of your home? If yes, persons name and relationship to you: _____	YES	NO	

I have been advised of the office's 'Notice of Privacy Practices'. Initial _____ Date _____

PATIENT FINANCIAL POLICY

We are committed to providing you and your family the best possible care. In order to achieve this, we ask for your cooperation with our payment policy. Please read over the details of this form carefully. Complying with the information below will help us in billing your insurance claims.

- A copy of your current insurance ID card. We need a copy of this in your file.
- If your insurance requires a referral, it is your responsibility to get a referral from your primary care physician to our office, prior to your appointment.
- As a courtesy, we will bill your insurance. You are responsible for meeting all deductibles and/or co-insurance amounts required by your policy. If you do not have insurance, payment is due at time of service.
- Your insurance is a contract between you, your employer, and your insurance company.
- It is your responsibility to inform us of any changes in your insurance coverage, employment or address.
- We will file Medicare and a secondary or supplemental policy. You will receive a bill for any amount approved by Medicare but not paid by your secondary plan.
- If you do not have your insurance card or if insurance cannot be verified before you check out, you are required to sign a waiver stating you understand that you, personally, are responsible for the balance.
- Payment for cosmetic products and/or procedures is required in full at the time services are rendered.
- Services deemed cosmetic/not medically necessary by insurance company are the responsibility of the patient.
- It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.
- Patch testing usually requires a co-pay for each visit of the test, which is normally 3 visits. Please confirm that your insurance company covers this procedure as not all do.
- If liquid nitrogen (often called freezing) is used as a treatment, codes used are considered a surgical procedure by insurance, and must be billed as such.
- Patient balances over 60 days will be subject to a 1.5% monthly finance charge.
- We do not offer professional courtesy discounts.
- If a biopsy is done, you will receive a separate charge for pathology reading by:
Solano Dermatology Associates (John Geisse, MD)

I have read and understand this financial policy and agree to abide by the terms and expectations listed above.

PATIENT NAME _____ **DOB:** _____
Last First

Patient/Parent signature: _____ Date: _____

Treatment of Minors

To be completed and signed by parent/legal guardian

For many families it is difficult to accompany your child to each visit. If your child needs multiple visits, your signature below will allow us to treat them *in your absence*.

I give permission for my child _____ to be treated at Solano Dermatology Associates in my absence.