

**Dermatology and Skin Surgery Center, P.A. – Dean R. Goodless, MD
Financial Policy, Consent and Authorization Form**

Name: _____ Date: _____

_____ Copayments and deductibles are due at the time of service. You may have an additional copay or deductible for surgical procedures over and above those for your office visit, ie: freezing, biopsy, etc. You will be billed for any additional charges your insurance company says are your responsibility after your claim is processed.

_____ All laboratory fees are billed directly by the lab to you or your insurance company

_____ There is a charge of \$25 for missed appointments and \$50 for missed surgeries not cancelled at least 48 hours in advance.

_____ There is no guarantee that one treatment will be sufficient to treat your problem. Each additional treatment, if required will entail additional charges, ie: re-treatment of warts, etc.

_____ Our office “policies and procedures” are on display in the waiting room and each exam room, and downloadable from our website at www.drgoodskin.com. By allowing Dr. Goodless to treat you, you agree to abide by these policies.

_____ All medical treatment entails risk including but not limited to: lack of improvement, reaction to medications, worsening of condition, and for surgery: lack of diagnosis, bleeding, infection, scarring, keloid formation, damage to nerves responsible for sensation and movement as well as incomplete removal or recurrence of skin cancers. As a patient of this practice, you understand that these risks are inherent in the practice of medicine and that you wish to receive treatment from Dr. Goodless.

You hereby authorize payment of medical benefits by your insurance company to Dermatology and Skin Surgery Center, PA/Dean R. Goodless, M.D.

ALL PATIENTS SIGN HERE: _____ DATE: _____

Additional material for Medicare Patients:

This office is required to keep your signature on file authorizing us to file claims to medicare for you and to release information to that payor if they require it for proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other information about me to release to the social security administration and health care financing administration and CMS or its intermediaries or carriers any information needed for this or a related medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to medicare assignment of benefits apply.

MEDICARE PATIENTS SIGN HERE: _____ DATE: _____