Shore DERMATOLOGY

AUTHORIZATION FOR BENEFIT ASSIGNMENT:

I hereby assign any benefits payable to Tamy Buckel, M.D. or Shore Dermatology for providing medical services. I understand that I am responsible for any balance in excess of the benefits/contract payable by this plan. I certify that the information I have reported to Tamy Buckel, M.D. with regard to my insurance coverage is correct. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. I further understand and agree that co-pays are to be collected at the time of service and that the patient is responsible for such charges. In addition, I understand that there will be a $25 charge for any returned check, and I am also responsible for any additional charges incurred if my account is forwarded to a collections agency. I also understand any appointment cancelled with less than 24hours notice or I fail to show for an appointment, I will be responsible for a $25 service fee and may be dismissed from the practice if I fail to show up for three or more appointments.

I also understand and agree that if my insurance requires a referral and I fail to bring/obtain a referral from my primary care physician at the time services are rendered, I will be responsible for the customary and reasonable fees associated with the office visit or I will have to reschedule.

I understand and agree that if Shore Dermatology does not participate with my secondary insurances that I am responsible for any balance that is not covered by my primary insurance.

If I am a self pay patient, I understand that the full amount charged is my responsibility and that a financial plan may be arranged if necessary.

INFORMATION RELEASE AND "NOTICE OF PRIVACY PRACTICES":

Shore Dermatology may disclose information about me and the treatment I am receiving, including copies of my medical record, to: (1) my insurance carrier, (2) any person or firm which conducts reviews of my treatment on behalf of my insurance company, and (3) the peer review organization designated by the appropriate governmental bodies to review hospital/physician utilization under the Medicare program. This information will be used by these parties to determine the medical necessity of the services I am receiving, to improve the quality of services provided, and to process payment for all or part of my hospital/physician bill. This authorization applies to all visits to this practice site for this calendar year and all other services provided by Shore Dermatology associated with those visits.

Shore Dermatology is required by federal law to maintain the privacy of health information that is protected by law, and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. Our "Notice of Privacy Practices" is available in the office for your review. I understand that the "Notice of Privacy Practices" is available upon request.

By signing below, I agree that I have read, understand and agree with this contract.

_____	_____	___/_____/___	_____
SIGNATURE OF PATIENT	NAME (PLEASE PRINT)	TODAY'S DATE	RELATIONSHIP TO PATIENT

Updated: 3/20/2018