INTEGRATED
DERMATOLOGY
OF NORTH RALEIGH

Angela Macri, DO., FAAD

Patient Financial Responsibility Form

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company regarding your coverage. It is **your responsibility** to know your individual coverage. **Failure** to comply could result in you, the patient, being responsible for **all** costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

To assist you in finding out what coverage you have, feel free to ask for assistance in finding the phone numbers or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement, it will be your responsibility to furnish this referral prior to your appointment. **Failure** to do so may require you to reschedule your appointment and/or accept full responsibility for payment. Some insurances state you **cannot** go out of network. Many companies have instituted a mandatory second opinion program, and these are changing day by day. We **cannot** keep up with the changes and are often unaware of them until it is too late.

Our office requires twenty-four (24) hours for cancellations. If you fail to comply you may be charged a $50 no show fee for an office visit appointment or a $100 fee for a surgery or cosmetic visit on your first occurrence. Each surgery/cosmetic occurrence will increase $100. If you have 5 or more cancellations within a calendar year, your account will be reviewed as to whether our office will continue to provide care for you.

Please call your insurance company and learn about your coverage, it may save a lot of confusion for all parties. Thank you.

This consent was signed by: _____
Patient Name – Patient Representative

_____/_____/_____/_
Signature Date

Relationship to Patient
(if other that patient) _____

Assignment of Benefits and Records Release: I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of N. Raleigh, LLC of any medical benefits payable to me for services provided at Integrated Dermatology of N. Raleigh, LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are submitted for insurance claims processing or as long as dictated by the payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

Patient Signature or Signature of Guardian or Parent **Date**

Medicare Patients Only – Lifetime Signature on File and Lifetime Consent
I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of N. Raleigh, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology of N. Raleigh, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature or Signature of Guardian or Parent **Date**