BRYKERWOOD SKIN AND VEIN CENTER
NEW PATIENT INFORMATION

ASSIGNMENT / RELEASE

- I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such medical care to third party payers including Medicare.

- If my insurance is in network, I assign my medical insurance to pay the billed charges. I understand that my medical insurance company may pay less than the billed charges. I agree that I may be responsible for payment of services rendered on my behalf or my dependents.

- I understand I may be billed from an outside laboratory for pathology or lab charges. These services are separate from any procedures done in this office.

FINANCIAL POLICY

- We accept CASH, CHECKS-with valid driver's license, MASTERCARD, VISA and AMERICAN EXPRESS.
  **There will be a $35.00 return check fee assessed to patients account for each returned check.*

- If copies of your medical records are needed, we require patients to sign a medical record release. The fee for record copying is $25.00.

- If you have any balance due from deductibles, co-insurance etc., statements will be sent out monthly. Payment is considered due for the full amount when you receive your statement. Sometimes the insurance companies give us incorrect benefit information in which we don't find out until the claim has been filed. You will be responsible for any payment due in this case. Payment plans are not available.

- If your insurance company requires preauthorization for prescriptions, there is a fee of $25.00 This is an additional service that is not reimbursable to us by your insurance company.

- **We require a 24-hour notification prior to cancellations for all appointments. The following are the cancellation fees.**
  <OFFICE VISIT $50
  <SURGERY $200
  <AESTHETIC or COSMETIC TREATMENT The cost of the procedure.
  As a courtesy, we call to remind you of your appointment 48-72 hours in advance. You are still responsible for your appointment, even if we are unable to contact you. Please make sure have updated the numbers where you can be reached.

I have read and understand the above Authorization/Release and Financial Policy and agree to the terms.

Patient Name (print) ____ Date_________________

Patient / Responsible Party Signature ____ Date ________________

Clinic Representative ____ Date _________________