Psoriasis & Eczema
TREATMENT CENTER
BY H2|DERMATOLOGY

Your Privacy:

I have been informed of the Notice of Privacy Practices for **Psoriasis & Eczema Treatment Center by H2 Dermatology**.

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Signature Date

Financial Policy: Patients who are covered by private, commercial plans in which our physicians do not participate are required to pay 100% of the bill at the time of service. If covered by a plan with whom we have a contract, applicable copayments and deductibles will be collected at the time of service, if determinable. You are responsible for paying 100% of non-covered or cosmetic services. Payment for amounts billed to you is due within 20 days of receiving a statement. Your signature indicates your willingness to comply with this policy.

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Signature Date

Authorization for Payment: I authorize the release of information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits directly to the physician.

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Signature Date

Special Authorization for Medicare Patients Only:

I request that payment of authorized Medicare benefits be made on my behalf to **Psoriasis & Eczema Treatment Center by H2 Dermatology** for any services furnished me by their providers. I authorize the release of information to the Centers for Medicare and Medicaid Services and its agents to determine benefits and payment of the claim. If "other health insurance" is indicated I authorize releasing of the information to the insurer or agency shown. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for co-insurance and deductible amounts as directed by my Medicare carrier. **(Psoriasis & Eczema Treatment Center by H2 Dermatology is a participating provider.)**

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Signature Date