Please initial next to each section

_____ **AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:**

I authorize the release of any medical information necessary to process any claim associated with Vista Dermatology and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

_____ **ASSIGNMENT OF INSURANCE BENEFITS:**

I authorize payment of benefits to be paid directly to the affiliated providers of Vista Dermatology, PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

_____ **CONSENT FOR TREATMENT AND PHOTOGRAPHY:**

I hereby authorize the Vista Dermatology, PLLC and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary for diagnosis and/or treatment. I understand that during the visit, photographs may be taken for clinical purposes (e.g. before skin biopsy or cosmetic procedure).

_____ **PATIENT PAYMENT RESPONSIBILITY:**

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered. Payment for Cosmetic Services is due at the time of service and are non-refundable. Many insurance plans assign payment responsibility to the patient for biopsies, excisions, cryotherapy and other minor surgical procedures performed in your doctor's office as a part of an outpatient surgical deductible. This charge may be in addition to any office co-pay and co-insurance your plan has designated for you. We will make every effort to provide you an estimate prior to your procedure.

Please note that not all removals are permanent. Viral warts and skin conditions can recur. Subsequent treatments are still billable procedures and if you plan assigns payment responsibility to you, you will be responsible for payment of services rendered.

_____ **APPOINTMENT CANCELLATIONS:**

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled. I understand there is a $25 No Show Fee for medical visits and a $50 No Show Fee for cosmetic and surgical appointments.

_____ **AUDIO/VIDEO RECORDINGS AND PHOTOGRAPHY POLICY:**

I understand no audio records, video records, and/or photography is allowed by the patient or by accompanying visitor or family during the clinic, cosmetic, or surgical visit.

_____ **CHANGE OF INFORMATION:**

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

_____ **NOTICE OF PRIVACY PRACTICES:**

Vista Dermatology and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that Vista Dermatology, PLLC and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

______________________________ Date ____________ ____________________________________

Patient Name (Please Print) Date Patient / Guardian Signature