

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Michelle.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update: ___/___/___

Patient Name: _____

Do we have permission to:

- Leave a message on your answering machine at home? YES NO
- Leave a message at your place of employment? YES NO
- Discuss your medical condition with any member of your household? YES NO

PAYMENT POLICY

Medicare: We are participating providers of the Medicare program. We will accept Medicare assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. Our office will file secondary insurance claims with insurance carriers that automatically cross over from Florida Medicare (Medigap). For all others, patients are responsible for paying their 20% copayment, although our office may submit a claim on your behalf as a courtesy.

Insurance plans with which we have contracts: You will be responsible for paying your annual deductible, co-payment, and charges for any non-covered, cosmetic services.

Insurance plans that we do not accept: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay for services at the time that they are rendered unless payment arrangements are made prior to the visit.

ALL PATIENTS:

- (1) If you have joined (or changed to) any managed care plan (HMO, PPO, Medicare HMO, etc.) you must inform the staff by providing a copy of your insurance care before your visit. Please note that if you fail to do so, you will be *personally* responsible for any and all amounts due that we are unable to collect from your insurance plan.
- (2) There will be a \$25 service charge for any returned checks.
- (3) Payments are due within 10 days of your receipt of any mailed billing statement. Accounts that are past due will be subject to a monthly 1.5% interest charge.
- (4) Overdue accounts may be sent to collections. You will be responsible for any and all collection fees required for us to collect the full amount due.

Patient or Responsible Party Signature: _____ **Date:** ____ / ____ / ____

ASSIGNMENT AND RELEASE

LIFETIME AUTHORIZATION: I hereby authorize payment directly to RSB Dermatology, Inc. or Robert S. Bader, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance, and for all services rendered on my behalf or my dependents.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the doctor/practice to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I authorize the above and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance companies.

X
(Responsible party's signature) (date)

FOR MEDICARE PATIENTS ONLY: LIFETIME AUTHORIZATION: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

X
(Patient's signature) (date)

FOR MEDICARE/MEDIGAP (Medicare Secondary Insurance) PATIENTS ONLY: LIFETIME

AUTHORIZATION: I request that payment of authorized Medigap benefits be made on my behalf to RSB Dermatology, Inc. for services rendered by RSB Dermatology, Inc. I authorize any holder of medical information about me to release to my insurance carrier (listed above) any information needed to determine these benefits of the benefits payable for related services.

X
(Patient's signature) (date)