Delmarva Dermatology LLC

DMVDERM.COM

PATIENT NAME: _____

OFFICE POLICIES

ASSIGNMENT OF BENEFITS:

I hereby authorize the physicians and staff of Delmarva Dermatology, LLC, to render treatment to me or my dependents. I further authorize Delmarva Dermatology to release my personal health information for purposes of treatment, payment or operations by phone, mail, fax, or electronically. I assign and authorize payment of medical or surgical benefits directly to Delmarva Dermatology, LLC. I understand that any unpaid balances or non-covered balances will be my responsibility. I also understand that I will be charged a $35 returned check fee for any and all returned checks. We accept cash, checks, MasterCard, Visa, American Express and Discover as forms of payment.

Medical Photographs:

I understand that photographs may be taken of my body and/or skin condition for inclusion in my medical record.

SKIN TAGS:
Skin tags are considered “cosmetic” and therefore are not a covered service by the insurance company. There will be a fee associated with the removal of skin tags. It is at the provider’s sole discretion to determine if the skin tag can be submitted to the insurance company for any medical reasons.

COPAYS:
Copays are due at the time of service.
By my signature, I acknowledge that I have read and understand the above-referenced information.

_____
Signature of Patient or Responsible Party (if patient is a minor)

Date:_____

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