



Consent for Treatment and Agreement to Pay

I. CONSENT FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician at PHD. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician. Further, I understand that should any medical personnel, physician, or other person be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Palm Harbor Dermatology.

II. AGREEMENT TO PAY

I acknowledge and agree that I am responsible for and will pay for all regular charges, which are contained in the applicable Palm Harbor Dermatology pricelist which is in effect on the dates of services rendered, for items or services and treatment provided to me, including any amount not paid by my insurance plan. I understand that I can request additional information about charges for procedures, devices, pharmaceuticals, and other items or services, or can obtain a non-binding estimate prior, or subsequent, to signing this agreement.

I understand that some items or services that PHD may provide to me may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services or items or services in excess of the limits in my member benefit agreement. Examples of items or services that may be deemed to be non-covered include cosmetic, personal convenience items, and certain medical supplies. I understand that I am personally responsible for any item or service determined by my third party payor (my insurance company) to be non-covered for any reason.

I understand that I am personally responsible for any non-covered Medicare, or Medicaid, CHAMPUS items or service that are listed on the financial responsibility for non-covered items or services form. I understand that I am personally responsible for deductibles and co-insurance established by my member benefit agreement, including those required for in-network laboratory and other ancillary services or items.

I hereby agree that if PHD has agreed to bill my insurance or other third-party carrier, it has agreed to do so as a courtesy, and that PHD has the right, should PHD deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third-party carrier, unless PHD and my insurance company or third-party carrier have agreed that I will not be billed.

I understand and agree that I have been advised that I may be billed by PHD and that this Assignment of Benefits and Agreement to pay applies to any and all PHD physician services. If a delinquent account referred for collection, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

III. ASSIGNMENT OF BENEFITS

I hereby authorize and request all insurance carriers, health maintenance organizations or managed care organizations with whom I have coverage, including Medicare, Medicaid, and CHAMPUS to pay directly to Palm Harbor Dermatology, and any and all benefits due under the terms of my policy for items or services provided by PHD, including any settlements or judgments for such items or services. If my health insurance will not allow direct payment to PHD, I agree to immediately forward to PHD all health insurance payments I receive for my care.

IV. GUARANTOR AGREEMENT

By signing in the space below as Patient/Legal Representative or Guarantor, I hereby agree that all charges connected with this treatment or any other treatment rendered to the above patient past or future, not covered by any insurance program, sponsorship or other third party coverage I may have are due and payable at the time of discharge or discontinuation of treatment. I understand that upon request I may be given a non-binding estimate of my charges. I hereby acknowledge having been told that I may be billed by PHD and that this assignment and guarantor agreement shall be allowed to cover any and all accounts, including PHD physician accounts. If the delinquent account is referred for collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process.

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING BELOW

Please Print Patient's Name: _____

Patient and/or Legal Rep Signature: _____ Date: _____ Time _____ AM/PM

Relationship to Patient _____

Guarantor _____ Date: _____ Time _____ AM/PM
(If other than patient/legal representative)

Witness _____ Date: _____ Time _____ AM/PM