INFORMED PATIENT CONSENT / FINANCIAL POLICY

I give my permission for the physicians and staff of Sunshine State Dermatology and Skin Cancer Center to treat me as deemed necessary in the exercise of their professional judgment.

I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow up care and call the office to note any changes or concerns in my condition.

I authorize my doctor to release my information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare.

I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or Medical Group any benefits for services rendered.

I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependence. I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

Cancellation/ No show policy: In order to provide the best possible service and availability to our patients, it is our policy to charge a fee of $50 for office visit appointments, $100 for scheduled surgical appointments not canceled or canceled at least 24 hours prior to appointment time. If you are having a cosmetic procedure, it is our policy to charge a deposit if it's not canceled 24 hours prior. Please call us as early as possible if you need to reschedule your appointment.

Returned Check policy: a $50 fee will be charged to your account for all return checks.

Collection policy: all accounts over 90 days past due may be turned to an outside collection agency for further processing and may incur additional collection and attorney fees.

Refund Policy: We do not offer refunds for medical and cosmetic procedures. Product returns are limited to company policy.

I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

Patient Name:______________________________________Date:____________

Patient Signature:___________________________________

Witness:____