



DERMATOLOGY Center of Richmond

Payment Arrangements continued:

*By signing this document, you hereby authorize all payments to Dermatology Center of Richmond, P.C. of any insurance benefits otherwise payable to you for services provided under any policy of insurance (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan).

*By signing this document, you authorize the release to insurance companies or other third party payers of their agents of any medical information which may be necessary to determine coverage or which may be required for utilization and quality review, utilization management, or continued care oversight.

*You are required, and you agree, to pay at the time of service any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance.

*In order to ensure you are scheduled efficiently, you will provide the office a 24-hour advance notice should you need to cancel your appointment for any reason. This allows the office to fill the vacant slot with other patients waiting to be seen. Should you neglect to do this and not arrive for your appointment, you will be billed a \$35.00 no-show fee.

*If Dermatology Center of Richmond, P.C. is not in network with your insurance plan, the practice will submit your claim, but you will be responsible for any unpaid amount from your billed services.

*Unpaid balances will be billed to your permanent address. You are responsible for paying the bill in full unless other arrangements have been approved in advance. There is a fee of \$35.00 for returned checks. Delinquent accounts will be turned over to our collection agency at time which you will be responsible for collection charges of 30% and all associated legal fees in addition to the amount owed.

*By signing this document, you authorize any photocopies of this document to be as valid as the original.

I have read, understand, and agree to the Treatment, Privacy and Payment Policies described above.

Patient or Guarantor Signature

Patient or Guarantor Printed Name

Date

*The term "you" and "your" as used in this document to mean the patients Guarantor. A Guarantor is the individual who accepts financial responsibility for services rendered to the patient. The Guarantor may be the patient, a family member, or non-family member. In the event that the patient is a minor or legally dependent person, then the Guarantor must have the authority to take action on the patient's behalf. By signing this form as "Guarantor" on behalf of a minor or legally dependent person, you represent to Dermatology Center of Richmond, P.C. that you have such authority.

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