Requirements of Subscriber:

All patients/subscriber's must give accurate personal and insurance information before seeing the doctor. Payment of copay, deductibles, and non-covered services are due at the time services are rendered. If they are not paid when services are rendered you will be charged a $5.00 late fee each time balances are unpaid. Ferrara Dermatology Clinic, P.C. accepts Cash, Personal/ Company checks (with proper identification) and visa/master/amex cards for payment of such services. A $25 return check fee will be issued for any checks that are returned for non-sufficient funds.

Dear Parents:

The adult accompanying and authorizing treatment of a minor at the time of service will be responsible for any payments due. For unaccompanied minors, non-emergency treatment can be provided in the event a written authorization from the parent/guardian is presented before the time of service. No minor will be seen without written consent from his/her parent or guardian.

Your signature below acknowledges your part in understanding the policies of the Ferrara Dermatology Clinic, P.C.

Patient/Subscriber/Parent Signature _____ Date _____

MEDICARE PATIENTS ONLY

Yes	No	
☐	☐	Have you recently joined a Medicare HMO? If Yes, please identify: _____
☐	☐	Do you or your spouse work in a company, which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by any Group plan that makes Medicare Secondary?
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to an injury at work?
☐	☐	Are you receiving Medicaid coverage?

Medicare Part B One Time Authorization Agreement

This office is required to keep your signature on file authorizing us to file claims to Medicare and to release information to that payor if they require it for the proper consideration of a claim.

I authorize Ferrara Dermatology Clinic, P.C. to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself, or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature _____ Date _____